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SAM COTTEN
SPEAKER OF THE HOUSE

MEMORANDUM

TO: Legislative Reference Library
FROM: Speaker Sam Cotten *SC*
DATE: January 2, 1991
RE: Liability Insurance Task Force

Enclosed in the box accompanying this letter are the records of the Liability Insurance Task Force from 1989 through 1990. I am forwarding these items to you for permanent filing.

A. Committee Tapes and Logs as follows:

1. Tapes for October 3-4, 1989, meeting (^{FIVE} ~~four~~ tapes)
2. Tapes and log for March 2, 1990 meeting (three tapes)
3. Tapes and log for March 3, 1990 meeting (five tapes)
4. Tape and log for March 16, 1990 meeting (one tape)

B. Set of 16 volumes of research data and index for same. Volumes are as follows:

1. Peer Review Panel Results, Etc.
2. Changes in Insurance Services: How the Public is Treated
3. Rand "Three Level" Study and Other Reports
4. Miscellaneous
5. Availability - Affordability Insurance Percentage
6. Availability of Services
7. Alternative Claim Resolution Mechanisms
8. Roles and Mechanisms of State Agencies
9. Claims Information Professional
10. Anti-Trust Suit Status
11. Impacts of U. S. Tort System Changes
12. Rates
13. Self-Regulation Materials
14. Changes in Time in Law of Liability and Damages

15. Comparisons of U. S. Tort System Changes
16. Legislative Research Agency Reports

C. Miscellaneous Handouts Used at 1989 Meetings as follows:

1. April 13, 1989 letter from Center for Study of Responsive Law.
2. MEDICAL ECONOMICS article "Tort Reform: What Works, and What Doesn't"
3. Copies of House Bill 166
4. February 17, 1989 memo from Michael F. Ford, Legislative Counsel, regarding Civil Action - HB 166
5. NATIONAL INSURANCE LAW REVIEW article "The Causes of the Medical Malpractice Crisis: An Analysis of Claims Data and Insurance Company Finances"
6. "New Ideas Concerning Organizations: The PIAA Proposal: Establishment of Fault by Either Administrative Review or Normal Adjudication Followed by Indemnification Using a Fixed Benefit Program."
7. August 5, 1988 letter from Milliman & Robertson, Inc.
8. "Who Should Be Liable? A Guide to Policy for Dealing with Risk."
9. "Insurance Rates, Regulation, Commissioner, Initiative Statute"
10. April 27, 1989 memo from Ginger Baim to David Rogers regarding House Bill 166 - pros.
11. September 15, 1989 memo from Rep. Cotten to Liability Insurance Task Force members
12. February 1986 report by the Citizens Coalition for Tort Reform entitled "Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability."
13. March 1987 report by the Tort Policy Working Group entitled "An Update on the Liability Crisis."
14. January 26, 1989 letter, James P. Lynn of Aetna from Ralph Nader and February 8, 1989 response from Aetna.
15. House Research Agency March 15, 1989 report on "Hawaii Court Annexed Arbitration Program."
16. October 1, 1985, "Report of the Governor's Medical Malpractice Insurance Commission."
17. April 25, 1989 statement from J. Robert Hunter, President, National Insurance Consumer Organization.

D. Miscellaneous papers regarding 1990 hearings:

1. March 9, 1990 list of Task Force members and alternates.
2. Memo from David Rogers regarding "Fact Finding Efforts" dated January 19, 1990.
3. Memo from David Rogers regarding "Summary of Data: Almost everything you ever wanted to know about liability issues (and were afraid to ask??)" dated February 22, 1990 and marked "draft".
4. March 2, 1990, Summary of Highlights - Discussion Draft. Prepared by David Rogers for Task Force members.

5. Letters and articles discussed at March hearings:

- a. January 26, 1990 letter from Scott Wetzel Services
- b. January 26, 1990 letter from Nabors Alaska Petroleum Services
- c. January 8, 1990 letter from David E. Rogers
- d. January 31, 1990 letter from Phillips Petroleum Company
- e. January 31, 1990 letter from NANA Regional Corporation, Inc.
- f. February 16, 1990 letter from City/Borough of Juneau
- g. February 16, 1990 letters from Wilton Adjustment Service
- h. March 1, 1990 letter from Alaska Bar Association
- i. NEW YORK TIMES articles concerning medical profession
- j. December 1, 1989 memo from John B. Gaguine, Legislative Counsel, concerning civil jury trials in other countries.
- k. February 23, 1990 letter from MICA
- l. February 27, 1990 letter from National Society of Professional Engineers

6. March 19, 1990 note and draft memo from David Rogers concerning tentative summary of claims experience information.

7. April 2, 1990 memo from Rep. Cotten to Task Force regarding MacNeil Lehrer Report and Harvard Study.

8. April 12, 1990 memo from Rep. Cotten to Task Force concerning Harvard Study materials.

9. June 17, 1990 draft final report.

C.1

CENTER FOR STUDY OF RESPONSIVE LAW

P.O. Box 19367
Washington, DC 20036
(202) 387-8030

April 13, 1989

Dear Interested Persons:

We have enclosed the following materials, which we hope will be of interest to you.

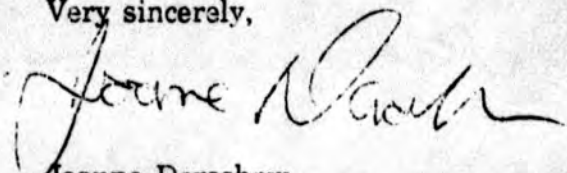
1. Fact sheets on automobile insurance and no-fault. Please be aware, however, that not all consumer groups agree on all points presented in the no-fault fact sheet. The National Insurance Consumer Organization, for example, supports a limited no-fault system, but only if full medical benefits are provided, as in Michigan -- something most insurance companies do not support. On the other hand, Ralph Nader does not support any type of no-fault system.

2. A detailed letter on what insurance companies should be doing in the area of safety and loss prevention, recently sent by Ralph Nader to Aetna chairman James P. Lynn. As you can see from Aetna's responses, which are also attached, the company has made no commitment to follow-up on the specific recommendations made in the letter.

This letter is valuable for several reasons. First, it is a comprehensive summary of what insurers could be doing to prevent accidents and why they have not made loss prevention a higher priority. Second, since Prop. 103 passed in California, the insurance industry has redoubled its efforts to co-opt consumer and public interest organizations at the national and state levels. Both publicly and privately, industry representatives have discussed the value of this "strategy" in their efforts to rebuild the insurance industry's public image. It is likely some of you may be approached by insurance representatives to discuss how you can "work together." This letter helps explain what public interest groups should expect from insurers, and what real commitment, as opposed to rhetoric, would look like.

We hope these materials are helpful. Please contact us if you have any questions.

Very sincerely,



Joanne Doroshow
Staff Attorney

FACTS ABOUT AUTO INSURANCE

- * During the past three years, auto insurance rates have risen at more than four times the rate of inflation, with even larger increases in some states.
- * Approximately 35 cents of each auto insurance premium dollar goes to pay expenses of various kinds, compared with 10 percent for health insurance. Agents' commissions and expenses connected with commissions account for about 16 cents out of each premium dollar. The total expense is approximately \$24.5 billion per year. This percentage has stayed constant over the past ten years: (34.2 for 1976-1981; 35.3 for 1981-1986; 34 for 1983-1988.)
- * Some major efficient and good service providers sell insurance for about 20 percent in expense costs. If the industry as a whole were able to compete at this level, auto insurance premiums could be reduced by 16.8 percent, or \$11.8 billion.
- * Insurance companies operate on a "cost plus percentage of costs basis." Their profit is based on a percentage of their projected costs, so the higher the cost, the greater the absolute dollar profit. Therefore, as presently constituted, insurance companies lack incentive to reduce claims and costs through better health and safety conditions.
- * The insurance industry is the only U.S. industry that is exempt from federal antitrust law, federal rate regulation, most state antitrust laws and meaningful state regulation in most states. In addition, most state laws prohibit insurance agents from competing, or lowering prices by reducing their commissions.
- * About 33 percent of the auto premium dollar goes for bodily injury costs, and 39 percent for property damage and theft.
- * Insurers frequently refuse to insure applicants with spotless driving records, forcing these consumers into a state "assigned risk" plan with generally higher rates. In New Jersey, for example, 78 percent of all assigned risks are clean, and this percentage is greatest in areas where the percentage of black and hispanic drivers is greatest.
- * Insurance companies do not advertise their prices, and applicants who ask agents for comparisons get the wrong answer one-third to one-half of the time.
- * According to data from the National Highway Traffic Safety Administration, approximately 5,000 lives are now being saved each year because of new laws which have taken effect this decade. Yet over this same period of time, auto rates have increased rapidly.
- * In its 1987 report "Trends in Tort Litigation," the insurance industry-funded Rand Corporation found that: auto litigation is a declining percentage of case filings; plaintiffs in auto cases involving modest injuries and expenses continue to obtain modest awards and, at least in recent years, these awards generally hold after trial; between 1980 and 1985, the average annual growth rate in insured defendants' average legal fees and expenses paid per claim was about 6 percent for auto (i.e., less than the rate of inflation); and, routine personal injury torts such as auto cases are growing slowly in frequency and costs, and their outcomes -- inflation adjusted -- have not changed much over the last 25 years.

HOW AUTO INSURANCE RATES CAN BE REDUCED

1. *Reduce expenses, or the costs an insurance company pays to run its business and pay claims.* This can be done through more effective state regulation, and removal of the current anti-competitive protections.

* **Repeal Antitrust Exemption.** Currently, the Insurance Services Office (ISO) sets "advisory" rates which all insurers use as a reference point in pricing, even though not all insurers adhere to these rate levels. ISO rates reflect what the least efficient company needs to make a profit. Repealing the antitrust exemption would prohibit ISO from issuing advisory rates. While companies would still have access to historical loss data, each company would have to project that data into the future itself using its own expense and profit factors to determine its rates.

* **Repeal Anti-Group Laws.** Unlike in the health or life insurance areas, most states currently prohibit auto insurance "group" plans. By banding together in a group, individual customers can increase their leverage, obtain lower rates and prod insurers to be more efficient. Consumers spend less time shopping and insurers expend fewer resources selling. (In 1986, Congress repealed anti-group laws for commercial risks).

* **Repeal Anti-Rebate Laws.** Currently, most states (not, for example, Florida or California) prevent competition among insurance agents by making it illegal for an agent to sell an insurance policy at a lower price by reducing his or her commission. The agents charge commissions set by the insurance companies. Thus, efficient agents can not lower commissions to compete for market share. These laws should be repealed.

* **Regulatory Rollback of Rates.** Where there has been an absence of competition and effective state rate regulation, insurers have raised rates to unreasonable and unjustified levels in many instances. A rate rollback, at 20 percent, for example, would be equivalent to a modest refund for prior years of insurance gouging.

* **Regulatory Approval of Rates.** The state department of insurance must be given authority to approve rates before their becoming effective, or approve those rates which fall above or below a certain range -- no more than 15 percent over the previous 12-month period. This authority should be combined with a public hearing requirement.

* **State Mandated Underwriting and Rating Criteria -- "Good Driver" Discount.** With very few exceptions, insurance companies now can reject an applicant for any reason or for no reason. In setting rates, most insurers give primary weight to territory (neighborhood), occupation, gender and marital status. Often times insurers will reject drivers with clean records. The state should establish, at a minimum, that an individual who meets "good driving" criteria have a legal right to buy insurance from any company doing business in the state and get a 20 percent discount. In setting rates, the key criteria should be: 1. driving record, 2. mileage (driving exposure) and 3. years of driving experience.

* **Computerized Consumer Information Service.** This should be set up by the state to allow insurance buyers to comparison shop. In addition to price information, the

state should make available information on: how long it takes to settle claims, the percentage of claims which go to court, the costs of providing insurance in the state, assessments of reserve accuracy, and similar information. Applicants would be able to either call an "800" number, or access computers to obtain this information.

* **More Accountable and Effective State Insurance Commissioners.** Insurance commissioners should be elected by the citizens, rather than serve as a revolving door advocate of the insurance industry. And commissioners' offices should be upgraded, with improved funding, systems for ongoing market conduct examinations, sufficient numbers of examiners and actuaries, automated systems and effective handling of consumer complaints.

* **Consumer Representation.** To foster effective and independent citizen representation, insurers should be required to notify all insureds, when they are billed, about the opportunity to join voluntary citizen advocacy organizations -- Citizen Insurance Boards -- for a small membership contribution. These groups would represent consumers' interests in rate proceedings and other insurance matters.

2. *Reduce "loss cost," or the amount the insurance company estimates is necessary to pay claims.* This can be done by requiring insurers to take into account risk factors that are likely to reduce or increase their costs, and to seek adoption of loss reduction policies by government and industry.

BODILY INJURY COSTS

* **Better Consumer Information.** The government should require ratings of vehicle crashworthiness placed on new car window stickers to assist buyers in selecting safer cars.

* **Air Bags.** In addition to mandatory regulations for air bags or their equivalents, insurance companies should retro-fit their cars with air bags, and equip their own entire company fleets with air bags as Travelers Insurance Co. has done.

* **Side Impact Protection.** Side impact protections standards should be upgraded to reduce thoracic/abdominal injuries, head injuries from contacts with the A-pillar, and side door ejection, particularly in car-to-car side impact crashes.

* **Rollover Protection.** A new safety standard for vehicle stability is needed, with a requirement for antilock brakes for these vehicles. Current minimal roof crush requirements should be upgraded and applied to vans and light trucks.

* **Light Truck and Van Safety.** The vehicles in this rapidly growing segment of the automotive market are used commonly as substitutes for cars, yet they do not have to comply with some key car safety standards. The car requirements for automatic restraints, head restraints, roof crush and side impact protection should be applied to these vehicles.

* **Large Truck Safety.** With 62 percent of truck occupant fatalities occurring in rollover crashes, improved handling and stability requirements are needed.

- * **Improved Steering Assemblies.** Steer assembly technologies which are more forgiving -- self-aligning, self-centering and padded -- should be required.
- * **Interior Component Improvements.** Better management of crash energy in frontal crashes is possible, such as eliminating hard surfaces on instrument panels, improving windshields, and padding the A-pillar and roof headers.
- * **Rear Seat Shoulder Harnesses.** Rear shoulder harness/lap belts are 8 percent to 10 percent more effective than lap belts alone.
- * **Pedestrian Crash Protection.** Pedestrians are consistently involved in 2 percent of highway crashes but account for 16 to 18 percent of fatalities. Long delayed standards to make striking vehicles more forgiving, and rules to soften the front ends of cars, reduce hood stiffness, lower underhood components, eliminate frontal protrusions and lower the impact surface below the bumper, are needed.
- * **Stronger Rules of the Road.** Insurance companies should push more strongly for:

Nationwide enactment of seat belt use laws;
 Repeal of the 65 mph speed limit;
 Better alcohol control on the highway;
 Motorcycle helmet use laws.

PROPERTY DAMAGE COSTS

- * **Reduce Damage in Low Speed Crashes.** The 5 mph bumper standard set in 1980 has been reduced to 2 1/2 mph, resulting in hundreds of millions more each year in unnecessary repair costs. The Department of Transportation should reissue this standard at 5 mph.
- * **Increase Competition to Lower Prices of Parts.** Aftermarket crash parts for years have been overpriced because of monopoly control by original equipment manufacturers, but this is beginning to change as more competition occurs, particularly from imports. State laws that prevent use of competitive replacement parts should be changed.
- * **Labor and Repair Cost.** If cars were better designed for repairability, there could be significant labor cost savings. Also, NHTSA should issue information by make and model of crashworthiness and damage susceptibility data. This information should be placed on new car window stickers.
- * **Control of Theft and Fraud.** Existing steering wheel lock, crash parts marking, and other federal standards to deter motor vehicle theft and fraud should be re-evaluated and upgraded. In addition, insurers should push auto companies to design more theft-resistant locks, especially GM whose locks car thieves have long known are easy to defeat.

From March, 1989 report, "Consumer Plan: To Cut Auto Insurance Rates 25%," National Insurance Consumer Organization and Public Citizen. Prepared by Center for Study of Responsive Law; (202) 387-8030.

###

THE PROBLEM WITH NO-FAULT AUTO INSURANCE

- **WHAT IS NO-FAULT AUTO INSURANCE?**

No-fault auto insurance is a system of compensating people injured in car accidents. It requires the victim to recover medical costs, lost wages and certain other economic expenses from his or her own insurance company and prohibits the victim from suing the individual at fault in the car accident.

- **WHAT ARE THE GOALS OF NO-FAULT AUTO INSURANCE?**

The major goals of no-fault are: to allow more injured victims to obtain quicker compensation for injuries; and to lower auto insurance rates.

- **HOW WELL DOES NO-FAULT AUTO INSURANCE ACCOMPLISH THESE GOALS?**

- **Compensating Victims**

Auto no-fault plans, particularly those which do not provide compensation for full medical benefits, can reduce the amount of compensation payable to most victims in the following ways:

- **No "Pain and Suffering" or "General Damages" are Allowed.** No-fault plans provide compensation for some amount of medical expenses, wage loss and other economic loss, depending on the benefit levels established by the no-fault law. However, no-fault plans preclude any compensation for the special circumstances of an individual injury, such as the extent to which the injury has permanently disrupted and reduced the quality of the victim's life, or caused pain and suffering.

For example, a victim immobilized by torn ligaments or painful massive muscle spasms can receive no compensation either for the pain suffered or for the effect the injury might have on the victim's daily life and family.

Senior citizens, homemakers and children, whose damages are not typically based on economic worth, are hit hardest by such limits.

In order for a victim who is not at fault in the accident to obtain compensation for this type of loss, the individual must bring a court action. However, most no-fault laws have strict monetary or verbal "thresholds" which prohibit such a "tort action" unless certain conditions are met.

- **Thresholds.** A "verbal threshold" means that a victim must suffer serious impairment of body function, permanent serious disfigurement, or death, to be able to sue. Monetary thresholds require the victim's medical damages to meet a certain limit before a court action is permitted. Verbal thresholds

are usually much more difficult to meet -- and much less fair to the victim -- than medical thresholds. They also invite litigation since verbal threshold categories are often vague and are subject to varying interpretations. New York, Michigan and Florida have "verbal thresholds."

- **Medical and Other Economic Losses Are Limited.** Most state no-fault plans preclude compensation for full medical expenses. Michigan is one notable exception. Michigan provides for unlimited medical and hospital expenses and past wages up to \$1,475 per month, adjusted annually to keep up with the Consumer Price Index. Florida's plan, on the other hand, limits medical benefits to only \$10,000, reimbursing only 80% of medical expenses and 60% of lost income. Many other plans are worse than Florida's.

- **Victims Are Without Assistance of Counsel in Dealing With Insurance Companies.** Insurers' resistance to pay a claim is the same, whether involving a third party under traditional liability rules, or a first party under no-fault. (No-fault pays only for the medical expenses of which an insurer approves.) The tendency to delay payment is the same, particularly if a large sum is at issue. Because victims under no-fault lose their rights to sue in court, they lose the best advantages they have in dealing with insurance companies -- access to attorneys, and the threat of a personal injury lawsuit.

The threat of a suit is often a more important factor in assuring the victim gets fair compensation than litigation itself. Even in traditional liability states, litigation is only a last resort for most claimants. Most cases are settled before a suit is filed, or before trial. Only a tiny percentage of the total claimants ever proceed to actually litigate a case. However, it is ultimate access to the legal system and the threat of a suit, where a judge or jury makes the decision, that helps restrain the insurance companies from exploiting their more powerful bargaining position and affording less than the deserved compensation.

- Lowering Rates

- **No-Fault Does Not Lower Rates.** This is particularly true when no-fault plans provide adequate medical and economic benefits. Michigan's insurance department has concluded in several studies that Michigan's no-fault law does not save money. The Department of Transportation's 1984 report showed that no-fault premiums in the final year of the study were 40 percent higher than premiums in tort states.

New York has a verbal threshold, and limits compensation to \$50,000 for medical benefits, and 80% of actual wage loss, with no more than \$1,000 per month. Rates dropped when New York enacted the verbal threshold. However, this was due primarily to increased state regulatory control over rates. Even so, auto insurance rates in New York remain among the highest in the nation.

- **An Analysis Released by "Project New Start," that No-Fault will Save Consumers \$3.7 Billion Annually in Premiums, is Bogus.** A organization called "New Start," representing itself as a "consumer organization," is traveling to states throughout the country advocating the adoption of no-fault with a verbal threshold -- a concept supported by the insurance industry. The group says it is funded by membership contributions, but it has obtained support and plans to

seek financial contributions from insurance companies. Other consumer groups, including the National Insurance Consumer Organization, the Consumer Federation of America and Consumers' Union, have disassociated themselves from Project New Start.

The group argues that such a plan would save consumer's \$3.7 billion annually. This figure is bogus because it does not properly factor in varying benefit levels -- one of the key determinants of rates under no-fault plans. Rather, the analysis evaluates as a group three verbal threshold states -- New York, Michigan and Florida -- each with widely varying benefit levels. Florida's benefits are woefully inadequate. New York's are not much better. The unfairly low benefits in these two states are probably the major reason New Start's analysis shows any savings at all.

And while victims get less, the total rate savings predicted by New Start amount to only \$3.7 billion -- less than 5 percent of the total auto premiums paid in this country. Most of this savings can be attributed to the low benefit levels in Florida and New York.

- **Premium Increases in No-Fault States Contributed to the Repeal of No-Fault in Pennsylvania, Nevada and South Carolina.**

- **One Reason No-Fault May Not Lower Rates is Because It Does Not Significantly Reduce Litigation.** As one commentator put it, "No-fault ... is a new game with new rules, causing new controversies.... No-fault has inherited issues that have given rise to extensive litigation in medical payments, and uninsured motorist coverage, such as the meaning of 'occupying' an automobile.... Whatever the advantages of no-fault, a reduction in court cases and court costs would not appear to be one of them." Risjord, "Does No-Fault Reduce Litigation?" *Insurance Counsel Journal*, July, 1986 at 389. Verbal threshold no-fault plans also can lead to an increase in litigation because of the controversy surrounding application of the threshold.

- **WHAT ARE SOME ADDITIONAL PROBLEMS CREATED BY AUTOMOBILE NO-FAULT PLANS?**

- **Some Evidence Suggests that No-Fault Can Lead to More Auto Accidents.** In their 1987 book *The Economic Structure of Tort Law*, conservative theorists William M. Landes and Richard A. Posner wrote that tort law deters auto accidents, even though liability insurance is widespread and personal safety might be expected to be of greater concern than the potential financial consequences of an accident. (Others have observed that driver safety may stem from fear over premium increases resulting from receiving a citation for a moving violation.) Landes and Posner, who say their review of the empirical literature relating to the effects of tort law on automobile accidents suggests that tort law leads to lower accident rates, reason that if the incentive to take care is reduced, probabilistically, people will be less careful, and the infrequent but cumulatively significant result will be more fatal accidents.

- **Under No-Fault, Drunk or Reckless Drivers Are Not Held Personally Responsible for their Conduct.** Under no-fault, the costs of injuries are misallocated -- by category

of drivers who suffer injury, not by category of drivers who cause injuries. Drunk and reckless drivers are excused from paying for the harm they cause, and instead, the victims' insurance company pays. Careful drivers end up subsidizing negligent drivers.

- **WHAT ABOUT GIVING CONSUMERS THE OPPORTUNITY TO CHOOSE EITHER A NO-FAULT OR TRADITIONAL LIABILITY POLICY?**

Some have argued in favor of giving consumers a choice between a no-fault and a traditional liability policy. However, in practice, such a system is unworkable and discriminates against the individual who chooses the traditional liability policy. If a consumer who chose to remain in the tort system were hit and injured by a no-fault policyholder, this victim would not have a tort remedy. The victim would be precluded from suing the no-fault policyholder, and would be forced to sue his or her own insurance company for compensation -- as if the victim were hit by an uninsured motorist. As greater numbers of consumers chose no-fault policies, chances would increase that the remaining tort policyholders would end up suing his or her insurance company for compensation. Thus, traditional liability rates would rise and no-fault rates would drop. Eventually, rates would be so different that a realistic choice would no longer exist.

- **WHAT ARE THE SOLUTIONS TO THE AUTO INSURANCE CRISIS?**

No-fault is no solution. Whatever savings are achieved under no-fault are at the expense of victims. The only real solutions to the auto insurance crisis are to force the insurance industry to operate more efficiently by eliminating state and federal antitrust exemptions, repealing anti-rebate laws and fictitious group laws; to enact regulatory controls over insurers' rates and practices, and to eliminate and reduce costs of claims by preventing injuries and deaths, reducing health care and repair costs, and cracking down on abuse and fraud. As long as insurers are permitted automatically to pass these costs through to their policyholders, they will have no incentive to reduce these costs and lower rates.

In addition, the tort liability system can be greatly improved by dealing with court congestion and unjustified delays by counsel; by improving access to the courts for victims through the development of more efficient economies of scale for servicing similar liability cases by lawyers; and by adequately disciplining abuses or legal malpractice. For example, arbitrary protective orders, and settlements in which insurance companies require that information they provide victims be kept completely confidential, should be prohibited where important safety information is involved. Easy access to this information not only could lead to hazard alerts and policies, from consumers and public agencies, but also could cut legal discovery costs and legal fees.

**SEE THE ACCOMPANYING FACT SHEET
ON REDUCING AUTOMOBILE INSURANCE RATES**

Prepared by the Center for Study of Responsive Law, P.O. Box 19367, Washington, DC, 20036, (202) 337-8030.

###

TORT REFORM: WHAT WORKS, AND WHAT DOESN'T

There are no sure bets. In some states, tort reform has reduced awards and slowed the rise in premiums. In others, it's been a flop.

By James E. Schutte SOUTHWEST EDITOR

Tort reform, say its critics, just isn't doing the job.

One of its chief goals—stabilizing malpractice premiums—hasn't been realized, despite round after round of legislative changes. Last May, in fact, the General Accounting Office concluded that tort reform offers no guarantee that insurance rates won't continue to increase.

Proponents, however, maintain that tort reform can pay off, making malpractice insurance not only more available but also more affordable. As proof, they cite the success of Indiana's Medical Malpractice Act of 1975.

Enacted while Otis R. Bowen, M.D., now U.S. Secretary of Health and Human Services, was governor, the Indiana statute limits a patient's total recovery to \$500,000. It also imposes a two-year statute of limitations on malpractice filings and provides for pretrial screen-

ing to determine the merits of a claim.

In the law's first 10 years, Indiana's major carrier posted no premium increases. When rates finally did go up, in 1985, the increase was just 12 percent. Premiums, which before the reforms had been higher than those of surrounding states, are now among the nation's lowest.

In some other states, though, tort reform has failed. In Florida, for instance, repeated legislative efforts have proved ineffective or, as in the case of the state's version of a pretrial screening panel, unconstitutional. Still, ever steeper malpractice premiums have goaded this state, like many others, to keep trying. Last February, the Florida legislature approved a statute that calls for increased arbitration of malpractice claims and ceilings on non-economic damages.

Meanwhile, the American

Medical Association, while saying it hasn't given up on efforts to fine-tune the jury system, wants to explore new alternatives. It recently unveiled a proposal to transfer medical-malpractice cases from the courts to a fault-based administrative system modeled along the lines of workers' compensation. For details on this proposal, see page 210.

Some "solutions" that haven't helped

Why are some reforms more effective than others? A number of studies have attempted to find out.

Several were written by Patricia Danzon, a health economist at the University of Pennsylvania and one of the most influential tort reform researchers. Another important study comes from the Physician Insurers Association of America, a coalition of doctor-owned mal-



The tort system doesn't make bad doctors accountable. The damage they do is paid for by good doctors through higher premiums for liability insurance.

LOUIS R. ZAKO, M.D.
Family Physician, Dearborn Heights, Mich.

practice insurance companies.

These studies analyze the most—and least—promising solutions. The latter include:

No-fault insurance. This is supposed to speed up settlements and reduce doctor-patient friction. But eliminating the concept of fault allows virtually any patient who suffers an adverse result to apply for compensation without having to prove negligence. A no-fault system in New Zealand has led one in five of that nation's inhabitants to file claims every year.

The PIAA estimates that a no-fault system in this country would mean a threefold to tenfold increase in the number of payouts. Even though the average payment might be lower than it is now, with marginal claims getting paid off at comparatively low levels, the over-

all impact would probably be a big increase in total payments.

Doctor-patient contracts. According to the PIAA, no document that holds a doctor harmless in the event of malpractice is likely to survive judicial scrutiny. Even contracts that merely limit a doctor's liability or require the arbitration of malpractice claims will probably get shot down in court.

Assessing legal fees to the loser. The only state to try this ploy has been Florida, which quickly scrapped it once before resurrecting it as part of its most recent tort reform legislation. The idea is to discourage suits by plaintiffs who, under the contingency-fee system, have everything to gain and nothing to lose. Trouble is, when a plaintiff loses, he can simply declare bankruptcy and walk away.

When a doctor loses, he not only has to pay off the judgment and his own lawyers, but the plaintiff's attorneys as well.

Under the new law, someone who appeals an arbitration award will be liable for the opposing party's expenses, including legal fees, if he fares less well in court than he did in front of the arbitration panel.

Arbitration. While most states provide for *voluntary* arbitration, experts agree that any attempt to make arbitration both mandatory and binding will almost certainly be seen as an unfair restriction on the right to a jury trial.

Arbitration, moreover, tends to encourage non-meritorious cases. According to the PIAA, arbitrators often arrive at compromises that result in payments to plaintiffs who would probably lose if their disputes

went to trial. Indeed, PIAA projections conclude that an increase in arbitration would actually raise rather than lower its carriers' expenses.

Such concerns notwithstanding, Florida has enacted a new arbitration program. Though this program is voluntary, a number of built-in incentives may promote its use.

These reforms seem promising

While some so-called solutions haven't helped, other reforms look like they might have a positive impact. Experts disagree about how much money they'd save, but these seem to be the most promising:

Caps on damages. Although some state courts have struck them down, the PIAA favors these caps, which would limit so-called "pain-and-suffering" awards. The United States Supreme Court in 1985 refused to hear a challenge to California's \$250,000 ceiling, which bodes well for similar ceilings in other states.

Caps on damages reduce the size, though not the frequency, of malpractice awards, according to health economist Patricia Danzon. She estimates that limits on non-economic damage would lead to a 23 percent reduction in malpractice payouts. The PIAA puts possi-

ble savings at 5 percent to 18 percent.

Pretrial screening. The objective here is to weed out suits that aren't meritorious and to encourage quick settlement of those that are. The potential for savings stems from the fact that, according to PIAA statistics, carriers spend an average of \$7,000 to process a claim—even if, as in two suits out of three, the plaintiff is never awarded any money. In other words, fewer suits mean lower costs.

Several states have established mandatory pretrial screening panels. Their findings are non-binding but often admissible in court. In Indiana, where this has been the keystone of tort reform, one carrier spent an average of only \$2,100 to defend a claim in 1986—in part because only 2 percent of that insurer's claims went to court.

Although pretrial screening reduces the number of malpractice trials and the total amount of money paid out, it may increase the number of claims filed. That's because plaintiff's attorneys frequently use the system to get comparatively quick and inexpensive payouts for marginal cases they'd otherwise turn down. Even so, pretrial screening saves carriers money in the long run by dis-

couraging attorneys from taking non-meritorious cases to trial—especially where panel findings are admissible as evidence.

Subtracting other insurance reimbursements from the award. In many cases, a successful plaintiff can collect twice for medical expenses—once from his own health or disability insurer, then a second time from the sued doctor's malpractice carrier. In most states, collateral-source rules permit this kind of double dipping.

Advocates want the rules changed to require that multiple payments be revealed and subtracted from an award or settlement. How much would this save? Both Danzon and the PIAA foresee a 10 percent to 15 percent cut in malpractice carriers' expenses.

Periodic payments on large awards. Under these so-called structured settlements, awards beyond a certain threshold—typically \$100,000—are paid out in installments over a period of years. Should a plaintiff die before payment of the final installment, any money earmarked for ongoing medical care would not be paid.

Insurers contend that even plaintiffs benefit from such an arrangement, since it guarantees that their long-term needs

will be met. Under the system of lump-sum payments, plaintiffs typically exhaust their awards within five years.

Backers of structured settle-

ments contend that if a plaintiff wants all of his cash up front, he should have to accept a smaller settlement. For this and other reasons, the PIAA esti-

mates that periodic payments would save its member carriers about 6 percent a year. For more on periodic payments, see page 157.

WHAT THE STATES HAVE TRIED

Here's a state-by-state tally compiled by the American Medical Association of major tort reforms as of the end of 1987.

	Caps on awards	Periodic payments	Collateral-source offsets	Arbitration	Limits on attorney fees	Pretrial screening
	1	1	1a	1		
	1	1	1	1		1
			2a		1b	2
						3
	2	2	2a	1	2	
	1		1		1b	1c
		3	1		1	1
			1a		1	1
	3	2	2	1	2	1c
	1		1a	1		
	1				1b	1c
	1		3		3	1c
	3	2	2	1	2	3
	2		1a		2	2
			2		1b	
	1	1	3		1b	1c
	1	1		1		2
		1		3	1	1
	1				1b	1
	1		1		1	2
	1	1	1	2	1	1d
	1		1			

1—Enacted

2—Upheld by state Supreme Court

3—No longer in effect (expired, overturned, or repealed)

a—Collateral sources must be disclosed, but court or jury will decide whether to subtract from award

b—Attorney fees not automatically limited, but will be reviewed by court for "reasonableness"

c—Decision of screening panel is not admissible during trial

d—Statute doesn't say whether or not panel's decision is admissible

Contingency-fee limits. The GAO-sponsored Tort Policy Working Group has proposed a sliding scale for attorney's fees. Under this scale, a plaintiff's at-

torney would get 25 percent of the first \$100,000 of an award and a lesser percentage of anything over that amount. Above \$300,000, an attorney's fee

would level off at 10 percent.

Plaintiffs would surely welcome this reform; under the present system, lawyers sometimes claim more than half of a

trial
ning

	Caps on awards	Periodic payments	Collateral-source offsets	Arbitration	Limits on attorney fees	Pretrial screening
	1	1				3
		1	1			2
	2		2		2b	2
						1
	1		3		1b	1c
			1		1	3
	1	1				1c
		1	1	1	1	2
	3	1	1	3		3
	1	1	1	1		2c
					1	
	1		1a		1	
			3		3	3
			1			3
		1				
	1	1	1a	1		
			1		1	3
	1					
	1	1	1	1	1	1c
				1		
	1			1		1
	1	1	1a		1b	
	1					
	1	3			1	3
					1b	1c

malpractice award. Many doctors also would like it—and the slap it takes at lawyers' earnings—even if it didn't save money for insurers. But the PIAA reports that contingency-fee limits would be likely to result in savings—an estimated 9 percent of payouts—by reducing the financial incentives for lawyers to hold out for large awards.

Shorter durations for statutes of limitation. This reform

THE AMA TRIES ITS HAND AT MALPRACTICE REFORM

Frustrated at being the passive victims of the malpractice crisis, the American Medical Association and 32 other medical groups have come up with their own ambitious solution.

In a plan released early this year, the AMA and its allies propose removing malpractice claims from the jury system, tightening the legal definition of liability, and beefing up discipline to help put bad doctors out of business.

"More patients injured by medical negligence will be compensated under this plan, and fewer dollars will be spent on meritless claims," says James S. Todd, M.D., AMA senior deputy executive vice president. He adds that several states have expressed interest in testing the plan, which would establish new state agencies to decide malpractice claims and take over physician licensing and discipline.

Under the proposal, any patient with a malpractice complaint could have it considered by his state's agency. Reviewers would start by deciding whether or not the case appeared to have merit. Patients with claims deemed to be legitimate would be offered free legal counsel. Others would have to hire their own lawyers if they chose to pursue their claims in the face of a negative assessment.

Each case would go to a state hearing examiner, who would have 90 days to decide whether to dismiss the matter or make an award. His decision would be reviewed by a medical board on which doctors would have minority representation. While the new system would supplant a patient's right to a jury trial, either doctors or patients could appeal procedural questions to state courts.

In deciding malpractice awards, the state agencies would adopt many popular features of recent malpractice reform legislation. Instead of having to prove that they'd met generally accepted standards of care, for example, accused doctors would have to show only that they'd acted as "prudent and competent practitioners."

The AMA would also change the liability standard to allow patients to recover damages anytime a doctor's negligence is a "contributing factor" in causing an injury—even if the physician is less than 50 percent at fault. The plan would cap non-economic damage awards at \$700,000, set periodic-payment schedules for damage awards exceeding \$250,000, and reduce awards by the amounts of collateral-source payments.

The new state agencies would also have investigatory branches assigned to monitor physician conduct, and they'd get expanded powers to put bad doctors out of business.

Because the AMA's proposal would limit frivolous claims and cut excessive pain-and-suffering awards, liability insurers say it could stabilize malpractice premiums. "The plan goes a long way toward dealing with some of the most serious problems of the current system," says Donald J. Fager, vice president of the Medical Liability Mutual Insurance Co.

But plaintiff's attorneys claim the plan could be challenged successfully on constitutional grounds. "In this country people have a right to a jury trial and redress for injuries and economic loss," says Baltimore plaintiff's attorney Marvin Ellin. "If the AMA doesn't like that, it'll just have to change the constitution."

XANAX® Tablets
(alprazolam) G

INDICATIONS AND USAGE

Anxiety disorders, short-term relief of the symptoms of anxiety, and anxiety associated with depression. Anxiety or tension associated with the stress of everyday life usually does not require an anxiolytic. Effectiveness for more than four months has not been established; periodically reassess the usefulness of the drug for the individual patient.

CONTRAINDICATIONS

Sensitivity to XANAX or other benzodiazepines, and in acute narrow angle glaucoma.

WARNINGS

Benzodiazepines can cause fetal harm in pregnant women, hence women who may become pregnant should be warned. Avoid during the first trimester. Withdrawal seizures have been reported upon rapid dose reduction or abrupt discontinuation, thus reduce dose gradually. (See Drug Abuse and Dependence and Dosage and Administration.)

PRECAUTIONS

General: If XANAX is combined with other psychotropics or anticonvulsants, consider drug potentiation. (See Drug Interactions.) Use the usual precautions in patients with renal or hepatic impairment and regarding prescription size in depressed and suicidal patients. In elderly and debilitated patients, use the lowest possible dose. (See Dosage and Administration.) Hypomania and mania has been reported in depressed patients.

Information for Patients: Alert patients about: (a) consumption of alcohol and drugs, (b) possible fetal abnormalities, (c) operating machinery or driving, (d) not increasing dose of the drug due to risk of dependence, (e) not stopping the drug abruptly.

Laboratory Tests: Not ordinarily required in otherwise healthy patients.

Drug Interactions: Additive CNS depressant effects with other psychotropics, anticonvulsants, antihistamines, ethanol and other CNS depressants. Plasma levels of imipramine and desipramine are increased. Pharmacokinetic interactions with other drugs have been reported. Cimetidine can delay clearance of benzodiazepines.

Drug/Laboratory Test Interactions: No consistent pattern for a drug or test.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No carcinogenic potential or impairment of fertility in rats.

Pregnancy: See Warnings. **Nonteratogenic Effects:** The child born of a mother on benzodiazepines may be at some risk for withdrawal symptoms, neonatal flaccidity and respiratory problems.

Labor and Delivery: No established use.

Nursing Mothers: Benzodiazepines are excreted in human milk. Women on XANAX should not nurse.

Pediatric Use: Safety and effectiveness in children below the age of 18 have not been established.

Adverse Reactions: Side effects are generally observed at the beginning of therapy and usually disappear with continued medication. In the usual patient, the most frequent side effects are likely to be an extension of the pharmacologic activity of XANAX, e.g., drowsiness or lightheadedness.

Central nervous system: Drowsiness, lightheadedness, depression, headache, confusion, insomnia, nervousness, syncope, dizziness, akathisia, and tiredness/sleepiness.

Gastrointestinal: Dry mouth, constipation, diarrhea, nausea/vomiting, and increased salivation.

Cardiovascular: Tachycardia/palpitations, and hypotension.

Sensory: Blurred vision.

Musculoskeletal: Rigidity and tremor.

Cutaneous: Dermatitis/allergy.

Other side effects: Nasal congestion, weight gain, and weight loss.

Withdrawal seizures with rapid decrease or abrupt discontinuation. (See Warnings.)

The following adverse events have been reported with benzodiazepines: dystonia, irritability, concentration difficulties, anorexia, transient amnesia or memory impairment, loss of coordination, fatigue, seizures, sedation, slurred speech, jaundice, musculoskeletal weakness, pruritus, diplopia, dysarthria, changes in libido, menstrual irregularities, incontinence, and urinary retention.

Paradoxical reactions such as stimulation, agitation, rage, increased muscle spasticity, sleep disturbances, and hallucinations may occur. Should these occur, discontinue the drug.

During prolonged treatment, periodic blood counts, urinalysis, and blood chemistry analysis are advisable. Minor EEG changes, of unknown significance, have been observed.

Liver enzyme elevations, gynecomastia and galactorrhea have been reported but no causal relationship was established.

DRUG ABUSE AND DEPENDENCE

Physical and Psychological Dependence: Withdrawal symptoms including seizures have occurred following abrupt discontinuance or rapid dose reduction of benzodiazepines. (See Warnings.) Dosage should be gradually tapered under close supervision. Patients with a history of seizures or epilepsy should not be abruptly withdrawn from XANAX. Addiction-prone individuals should be under careful surveillance.

Controlled Substance Class: XANAX is a controlled substance and has been assigned to schedule IV.

OVERDOSAGE

Manifestations include somnolence, confusion, impaired coordination, diminished reflexes and coma. No delayed reactions have been reported.

DOSE AND ADMINISTRATION

Dosage should be individualized.

The usual starting dose is 0.25 to 0.5 mg, t.i.d. Maximum total daily dose is 4 mg. In the elderly or debilitated, the usual starting dose is 0.25 mg, two or three times daily.

Reduce dosage gradually when terminating therapy, by no more than 0.5 mg every three days.

HOW SUPPLIED

XANAX Tablets are available as 0.25 mg, 0.5 mg, and 1 mg tablets.

CAUTION:

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION.

THE UPJOHN COMPANY
Kalamazoo, Michigan 49001, USA

1-9134
April 1988

Tort reform

would have three major benefits—reduced uncertainty and liability for carriers, faster resolution of claims, and more defensible cases for physicians. With a shorter statute, a doctor's memory would be fresher and he'd be less likely to lose track of records and witnesses.

According to Patricia Danzon, trimming one year from the statute of limitations—regardless of the length of a state's current limit—would reduce the frequency of claims by an average of 8 percent.

How to make tort reform pay off

There are two keys to getting the benefits of tort reform. One is realistic expectations. The other is patience.

Tort reform won't magically eliminate malpractice nightmares, and it probably won't even roll back premiums. But according to Danzon, it does offer other benefits.

She argues that the real crisis in malpractice insurance is caused by the present inability of carriers to predict future losses. In her view, most reforms that make payouts less volatile and more predictable are worthwhile, even if payouts continue to get bigger.

The advocates of patience point to California, where 10 years passed before doctors and insurers could enjoy the full

Tort reform

benefits of a tort reform law enacted in 1975. Not until 1985 were all major segments of that law upheld on appeal. Up to that point, plaintiff's attorneys and the courts sometimes ignored the law, assuming it would be ruled unconstitutional.

The California law includes a \$250,000 cap on non-economic losses, limits on contingency fees, and a shorter statute of limitations. It's credited with moderating the increases in malpractice premiums for California doctors since 1980.

Proponents of tort reform

contend that the political climate all over the country is ripe for further action. According to a March 1987 poll by Louis Harris and Associates, "Nine out of 10 Americans see a need for some changes to improve the civil justice system." In addition, two out of three say they approve of contingency-fee limits, collateral-payment offsets, and caps on "pain-and-suffering" awards—in other words, some of the most promising tort reforms.

But despite such nationwide sentiments, most medical and

"He's a good doctor, but I don't feel that he's interested in me!"



Of course her physician is interested! It's unfortunate that she has this perception, however, it needn't persist. Her physician should keep in touch . . . how? By writing to her with . . . **HEALTH BULLETIN.**

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"I was celebrating the recent strides in women's liberation."

Tort reform

legal experts consulted by the GAO believe that meaningful tort reform will have to be slugged out on a state-by-state basis. Federal legislation is unlikely to accomplish more than to provide financial incentives for state action.

HHS Secretary Bowen seems determined to do his part. Late

last year, he sent governors a model tort reform bill. It calls for pretrial, non-binding arbitration, a \$200,000 cap on non-economic damages, collateral-source offsets, periodic payments for awards over \$100,000, limits on contingency fees, and the elimination of joint-and-several liability.

No one knows, of course, how many states will adopt such measures, and nobody knows whether those that do will get the kinds of results Indiana and California have experienced. But with liability premiums still out of control, it seems likely that many states will continue to give tort reform a try.

THE MALPRACTICE CRISIS: WILL TORT REFORM HELP?

Doctors and insurance companies, attracted by the potential for savings in malpractice premiums and payouts, favor tort reform. Plaintiff's lawyers, put off by reform's power to curb patients' rights—and, presumably, attorneys' fees—are staunchly opposed.

Here's how our roundtable panelists assess the pros and cons:

Hawkins: Tort reform inevitably weakens a person's right to protect himself in court. Stripping a citizen of this right is to react hysterically to the so-called malpractice crisis.

Harney: I agree. The term "tort reform" is itself a misnomer. What is tort? It's a civil wrong. And how do you reform a civil wrong? All you can do is to avoid committing it in the first place.

Zako: But the problem with the tort system is that it doesn't make bad doctors accountable for their mistakes. Instead, the damage they do is paid for by good doctors through higher premiums for liability insurance and by the patients who absorb those costs. I consider that a civil wrong, too.

Breslin: The courts have been diligent in protecting the rights of the injured—so much so that even if a state enacts tort reform, odds are the law will eventually be ruled unconstitutional.

Penrod: That doesn't mean the situation is

hopeless. It took 10 years, but California's Medical Injury Compensation Reform Act of 1975 was eventually upheld. Even though the reforms were in legal limbo for a decade, California became the most stable marketplace in the country from the perspective of the medical-malpractice industry.

Rockett: Tort reform has had a similar effect in my state, Massachusetts. I understand that in the year after our legislation was enacted in 1986, 500 fewer medical-malpractice cases were filed than the year before.

Breslin: Still, I think the malpractice crisis will continue to worsen in most states because of the increasing amounts awarded for catastrophic injuries.

Penrod: But an increase in the size of individual awards isn't necessarily bad. The irony is that effective tort reform usually increases the average payout on malpractice claims. That's because the nuisance suits are weeded out, leaving only the solid, meritorious claims to be settled.

Sweetland: California's tort reform package is reasonable and efficient, but I doubt if other states will do as well. I think a fault-based administrative system like workers' compensation, with a schedule of benefits, is the only way to bring some stability to premiums for malpractice insurance. ■

MICA Medical Indemnity
Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

February 23, 1990

Representative David Donley, Chairman
House Labor and Commerce Committee
State of Alaska
P.O. Box V
Juneau, Alaska 99811

Dear Chairman Donley:

I was requested in a legislative hearing on Tuesday, February 20, to supply the committee with numbers of deliveries made per physician from information gathered on a questionnaire distributed by ASMA to private practice physicians in the state.

The information follows:

Family or General Practitioners doing Obstetrics

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Anchorage *		1	3	6		
Fairbanks		4	1			
Kenai Peninsula		2	4	3	1	
South East	1	3	6	3	1	
North				1**		

* - Anchorage includes Mat-Su Valley

** - covered by Federal Government

General Surgeons (C-Section only)

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
South East			1	1		

Obstetricians

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Anchorage			1***	2	11	3
Kenai Peninsula				1		
Fairbanks					4	

*** This physician noted that he only does 40 deliveries because CNA (his carrier) increases the rates with an increase in deliveries.

The following are the statistics I testified to during the hearings.

Total: 321 Uninsured: 48 or 15%
187 of total doctors reside in Anchorage

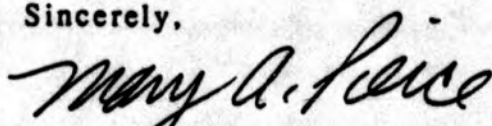
	<u>Delivering or Had Been Delivering Babies</u>	<u>Not Doing Deliveries</u>
Total	131	190
Uninsured	27 or 20.6%	21 or 11%
Uninsured Located	14 - Anchorage 7 - Kenai Peninsula 2 - Fairbanks 2 - North 2 - Southeast	14 - Anchorage 4 - Kenai Peninsula 3 - Southeast
Stopped Coverage before 1987	6	9
% of Gross Income willing to Pay		
Minimum	5%	1%
Maximum	25%	10%
Average	10%	5-10%
No Longer Delivering Babies	42 * or 32%	

* - 33 doctors in the insured group were no longer delivering babies all due to cost.

- 9 doctors in the uninsured group were no longer delivering babies partially due to cost.

I hope this information proves useful. I've attached a copy of the questionnaire form that was distributed to the 616 private practice physician.

Sincerely,



Mary A. Pierce
Executive Director, MICA

Deletions this side

Original sponsors: Cotten, Larson,
Hoffman, et al.

Additions this side

1 IN THE HOUSE

BY COTTEN, LARSON, HOFFMAN,
PETTYJOHN, GRUSSENDORF,
FOSTER, COLLINS AND BOUCHER

2 HOUSE BILL NO. 166

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to civil actions; amending Alaska
7 Rules of Civil Procedure 68 and 82; and providing for
8 an effective date."

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

10 * Section 1. FINDINGS AND PURPOSE. (a) Tort law in this state has
11 generally been developed by the courts on a case-by-case basis. While this
12 process has resulted in some significant changes in the law, including
13 amelioration of the harshness of many common law doctrines, the legislature
14 has periodically intervened in order to bring about needed reforms. The
15 purpose of this Act is to enact further reforms in order to create a more
16 equitable distribution of the cost and risk of injury and increase the
17 availability and affordability of insurance.

18 (b) The legislature finds that boroughs, cities, and other govern-
19 mental entities are faced with increased exposure to lawsuits and awards
20 and dramatic increases in the cost of insurance coverage. These escalating
21 costs ultimately affect the public through higher taxes, loss of essential
22 services, and loss of the protection provided by adequate insurance. In
23 order to improve the availability and affordability of quality governmental
24 services, comprehensive reform is necessary.

1 IN THE HOUSE

BY THE LABOR AND
COMMERCE COMMITTEE

2 CS FOR HOUSE BILL NO. 166 (L&C)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to civil actions; amending Alaska
7 Rule of Civil Procedure 68; and providing for an
8 effective date."

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

10 * Section 1. FINDINGS AND PURPOSE. (a) Civil justice in this state
11 has generally been developed by the courts on a case-by-case basis. This
12 process has resulted in some significant changes in the law, and the legis-
13 lature has periodically intervened to bring about needed reforms. The
14 purpose of this Act is to enact further reforms that create a more or ra-
15 ble distribution of the cost and risk of injury.

25 (c) The legislature also finds ~~comparable cost increases in profes-~~
 26 ~~sional liability insurance. Escalating malpractice insurance premiums~~
 27 ~~discourage physicians and other health care providers from initiating or~~
 28 ~~continuing their practice or offering needed services to the public and~~
 29 ~~contribute to the rising costs of consumer health care.~~ Other
 1 professionals, such as architects and engineers, face similar difficult
 2 choices, financial instability, and ~~unlimited risk~~ in providing services to
 3 the public.

4 (d) The legislature also finds that general liability insurance is
 5 becoming unavailable or unaffordable to many businesses, individuals, and
 6 nonprofit organizations in amounts sufficient to cover potential losses.
 7 High premiums have discouraged socially and economically desirable activ-
 8 ities and encourage many to go without adequate insurance coverage.

9 (e) The legislature also finds that citizens should be encouraged to
 10 serve as board members ~~and officers~~ of ~~public corporations and~~ electric or
 11 telephone cooperatives. These organizations serve important governmental
 12 functions, and their vitality and effectiveness depend upon the willingness
 13 of experienced individuals to seek leadership and decision-making roles
 14 within them. Accordingly, these board members ~~and officers~~ should be
 15 ~~protected~~ from liability arising from an act or omission within the scope
 16 of their duties, unless the act or omission constitutes gross negligence.

17 (f) It is the intent of the legislature to reduce costs associated
 18 with the ~~port~~ system, while ensuring that adequate and appropriate compen-
 19 sation for persons injured through the fault of others is available.

16 (b) The legislature also finds ~~that unnecessarily high~~ malpractice
 17 insurance premiums discourage physicians from initiating or continuing
 18 their practice or offering needed services to the public. Other profes-
 19 sionals, such as architects and engineers, face similar difficult choices,
 20 financial instability, and risk in providing services to the public.

21 (c) The legislature also finds that citizens should be encouraged to
 22 serve as board members of electric or telephone cooperatives. These orga-
 23 nizations serve important governmental functions, and their vitality and
 24 effectiveness depend upon the willingness of experienced individuals to
 25 seek leadership and decision-making roles within them. Accordingly, these
 26 board members should be ~~given some protection~~ from liability arising from
 27 an act or omission within the scope of their duties.

28 (d) It is the intent of the legislature to reduce costs associated
 29 with the ~~civil justice~~ system, while ensuring that adequate and appropriate
 1 compensation for persons injured through the fault of others is available.

2 (e) The legislature wishes to help match losses with compensation by
3 helping to
4 (1) ensure that money paid to an injured person is available
5 when anticipated expenses or losses occur;
6 (2) ensure that a claimant with substantial injury requiring
7 long-term treatment will have money available for future medical care;
8 (3) reduce medical reparation system costs by eliminating those
9 portions of awards that are not needed to compensate the claimant;
10 (4) eliminate duplicate recoveries; and
11 (5) reduce the costs of litigation.

12 (f) The legislature wishes to accumulate additional information about
13 the costs to society of the civil justice, health care, and insurance
14 systems as they are presently constituted. This information is necessary
15 to determine whether the civil justice, health care, and insurance systems
16 as they are presently constituted are fairly serving victims and whether a
17 disproportionate amount of compensation dollars are absorbed by the system.

18 (g) The legislature finds that it is extremely difficult to defend
19 against a claim that has become stale after information and witnesses have
20 disappeared. The legislature finds that on the whole society is better
21 served by a reasonable statute of repose even though in a few limited
22 instances injuries may go without compensation.

20 * Sec. 2. AS 09.10 is amended by adding a new section to read:

21 Sec. 09.10.052. CERTAIN ACTIONS THAT MUST BE BROUGHT IN SIX
22 YEARS. (a) Notwithstanding AS 09.10.140, a person may not bring an
23 action for personal injury, death, or property damage unless the
24 action is brought within six years of the earliest of

25 (1) the date a product alleged to have caused the personal
26 injury, death, or property damage was purchased;

27 (2) the date of substantial completion of the construction
28 alleged to have caused the personal injury, death, or property damage;

29 or

Deletions this side

Additions this side

1 (3) the date of the last act alleged to have caused the
2 personal injury, death, or property damage.

3 (b) This section does not apply if

4 (1) the personal injury, death, or property damage was
5 caused intentionally; or

6 (2) a shorter period of time for bringing the action is
7 imposed under another provision of law.

23 * Sec. 2. AS 09.10.035(a) is repealed and reenacted to read:

24 (a) Notwithstanding AS 09.10.140, a person may not bring an
25 action for personal injury, death, property damage, or indemnity
26 arising from a deficiency in the construction or the design, planning,
27 supervision, or observation of construction, of an improvement to real
28 property, unless the action is brought within 15 years of the date of
29 substantial completion of the improvement to real property.

1 * Sec. 3. AS 09.10.035(d) is amended to read:

2 (d) The limitation prescribed by this section may [SHALL] not be
3 asserted by way of defense by

4 (1) a person in actual possession or control, as owner,
5 tenant, or otherwise of an improvement at the time a deficiency in an
6 improvement is [CONSTITUTES] the proximate cause of the injury or
7 death; or

8 (2) in an action for damages resulting from the design,
9 planning, supervision, or observation of construction of a facility
10 for the transportation or storage of hazardous materials [FOR WHICH IT
11 IS PROPOSED TO BRING AN ACTION].

12 * Sec. 4. AS 09.10.055(e) is amended to read:
 13 (e) In this section,
 14 (1) "hazardous materials" means a material or substance
 15 that, when it enters into or on the surface or subsurface land, water,
 16 or atmosphere of the state, presents an imminent and substantial
 17 danger to the public health and welfare; "hazardous substance" in-
 18 cludes oil; in this paragraph "oil" has the meaning given in AS 46.-
 19 08.900;
 20 (2) "person" means an individual, corporation, partnership,
 21 business trust, unincorporated organization, association, or joint-
 22 stock company.

23 * Sec. 5. AS 09.10 is amended by adding a new section to read:
 24 Sec. 09.10.065. LIMITATION ON ACTIONS INVOLVING A PHYSICIAN.
 25 (a) Notwithstanding AS 09.10.140, an action based on professional
 26 negligence may not be brought against a physician by a person who is,
 27 on the date of the alleged negligent act or omission
 28 (1) 10 years of age or older, unless the action is brought
 29 within five years of the date of injury;
 1 (2) less than 10 years of age, unless the action is brought
 2 within five years of the date of injury, or before the person's 12th
 3 birthday, whichever period is longer.
 4 (b) The limitation imposed under (a) of this section is tolled
 5 during any period in which there exists
 6 (1) fraud, including fraud or collusion by a parent, guard-
 7 ian, insurer, or physician, resulting in the failure to bring on
 8 action on behalf of an injured minor;
 9 (2) intentional concealment; or
 10 (3) the undiscovered presence of a foreign body, that has
 11 no therapeutic or diagnostic purpose or effect, in the body of the
 12 injured person and the action is based on the presence of the foreign
 13 body.

8 * Sec. 3. AS 09.10.070 is amended to read:
 9 Sec. 09.10.070. ACTIONS TO BE BROUGHT IN TWO YEARS. A [NO]
 10 person may not bring an action (1) for libel, slander, assault, bat-
 11 tery, seduction, or false imprisonment [, OR FOR ANY INJURY TO THE
 12 PERSON OR RIGHTS OF ANOTHER NOT ARISING ON CONTRACT AND NOT SPECIF-
 13 ICALLY PROVIDED OTHERWISE]; (2) upon a statute for a forfeiture or
 14 penalty to the state; or (3) upon a liability created by statute,
 15 other than a penalty or forfeiture; unless commenced within two years.

14 (c) In this section,
 15 (1) "physician" means a person licensed under AS 08.64;
 16 (2) "professional negligence" means a negligent act or
 17 omission by a physician in rendering professional services;
 18 (3) "professional services" means services provided by a
 19 physician that are within the scope of services for which the physi-
 20 cian is licensed, and that are not prohibited under the physician's
 21 license or by a hospital in which the physician practices.

22 * Sec. 6. AS 09.10.070 is amended to read:
 23 Sec. 09.10.070. ACTIONS TO BE BROUGHT IN TWO YEARS. A [NO]
 24 person may not bring an action (1) for libel, slander, assault, bat-
 25 tery, seduction, or false imprisonment, or for any injury to the
 26 person or rights of another not arising on contract and not specif-
 27 ically provided otherwise; (2) upon a statute for a forfeiture or
 28 penalty to the state; or (3) upon a liability created by statute,
 29 other than a penalty or forfeiture; unless commenced within two years
 1 of the accrual of the action.

2 * Sec. 7. AS 09.10.070 is amended by adding new subsections to read:
 3 (b) Notwithstanding AS 09.10.140, the period of time within
 4 which a person may bring an action under (a)(1) of this section may
 5 not be extended for a disability described under AS 09.10.140, for
 6 more than 20 years after the date of the injury. This subsection does
 7 not apply if the injury is caused by an intentional act.
 8 (c) The limitation of (a) of this section does not apply to an
 9 action described in (a)(1) of this section if the period of limitation
 10 imposed under AS 09.10.063 applies, or if a shorter period of time for
 11 bringing the action is imposed under another provision of law.
 12 (d) In this section, "accrual" means the date that the person
 13 discovers or should have discovered the person's right to bring an
 14 action.

* Sec. 4. AS 09.10 is amended by adding a new section to read:

Sec. 09.10.075. LIMITATION ON ACTIONS INVOLVING INJURY TO PERSON OR PROPERTY. (a) Notwithstanding AS 09.10.140, a person may not bring an action for personal injury, death, or property damage unless the action is brought within two years of the accrual of the action.

(b) This section does not apply if a shorter period of time for bringing the action is imposed under another provision of law.

* Sec. 5. AS 09.17.020 is amended to read:

Sec. 09.17.020. PUNITIVE DAMAGES. Punitive damages may not be awarded in an action, whether in tort, contract, or otherwise, unless supported by clear and convincing evidence of malice, bad motive, or reckless indifference to the interests of another and conscious acts showing deliberate disregard by the defendant.

* Sec. 6. AS 09.17.030 is amended to read:

Sec. 09.17.030. DAMAGES RESULTING FROM COMMISSION OF A CRIME. A person who suffers personal injury or death may not recover damages for the personal injury or death if the injuries or death occurred while the person was engaged in the commission of a crime [FELONY], the person has been convicted of the crime [FELONY], including conviction based on a guilty plea or plea of nolo contendere, and the crime [FELONY] substantially contributed to the injury or death. This subsection [SECTION] does not affect a right of action under 42 U.S.C. 1983.

* Sec. 7. AS 09.17.030 is amended by adding new subsections to read:

(b) This section does not apply to a person who suffers personal injury or death if the person liable for the damages

(1) was engaged in the commission of a crime at the time the personal injury or death occurred; and

(2) has been convicted of the crime, including conviction based on a guilty plea or plea of nolo contendere.

(c) In this section "crime" has the meaning given in AS 11.81.-900(b).

* Sec. 8. AS 09.17.040(d) is amended to read:

(d) In an action to recover damages, the court shall, at the request of a [AN INJURED] party, enter judgment ordering that amounts awarded a judgment creditor for future damages be paid to the maximum extent feasible by periodic payments rather than by a lump-sum payment. If a portion of the judgment awarded is owed to an attorney under a contingent fee agreement, that portion of the judgment shall be reduced to present value and paid in a lump sum.

* Sec. 9. AS 09.17.040(f) is amended to read:

(f) A judgment ordering payment of future damages by periodic payment shall specify the recipient, the dollar amount of the payments, including any increases in future payments for anticipated inflation, the interval between payments, and the number of payments or the period of time over which payments shall be made. Payments may be modified only in the event of the death of the judgment creditor, in which case payments may not be reduced or terminated, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before death. In the event the judgment creditor owed no duty of support to dependents at the time of the judgment creditor's death, the money remaining shall be distributed in accordance with a will of the deceased judgment creditor accepted into probate or under the intestate laws of the state if the deceased had no will.

* Sec. 10. AS 09.17.050(a) is amended to read:

(a) Unless the act or omission constituted gross negligence, a person may not recover tort damages for personal injury, death, or damage to property for an act or omission to act in the course and scope of official duties, from [ONE OF] the following:

(1) a member of the board of directors or an officer of a nonprofit or public corporation;

* Sec. 8. AS 09.17.040(f) is amended to read:

(f) A judgment ordering payment of future damages by periodic payment shall specify the recipient, the dollar amount of the payments, the interval between payments, [AND] the number of payments or the period of time over which payments shall be made, and shall include an amount representing future payments for anticipated inflation. Payments may be modified only in the event of the death of the judgment creditor, in which case payments may not be reduced or terminated, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before death. In the event the judgment creditor owed no duty of support to dependents at the time of the judgment creditor's death, the money remaining shall be distributed in accordance with a will of the deceased judgment creditor accepted into probate or under the intestate laws of the state if the deceased had no will.

* Sec. 9. AS 09.17.050(a) is amended to read:

(a) Unless the act or omission constituted gross negligence, a person may not recover tort damages for personal injury, death, or damage to property for an act or omission to act in the course and scope of official duties, from [ONE OF] the following:

(1) a member of the board of directors or an officer of a nonprofit corporation;

Deletions this side

Additions this side

20 (2) a member of the board of directors of a public or
21 nonprofit hospital, or a member of a citizen's advisory board, of any
22 hospital;
23 (3) a member of a school board of a school district;
24 (4) a member of the governing body, a commission, or a
25 citizen's advisory committee of a municipality of the state;
26 (5) a member of the board of directors or an officer of an
27 electric or telephone cooperative organized under AS 10.25.

28 * Sec. 11. AS 09.17.070 is repealed and reenacted to read:

29 Sec. 09.17.070. COLLATERAL BENEFITS. Except when the collateral
1 source by law or contract must be repaid and except death benefits
2 paid under life insurance, a person may recover only damages that
3 exceed amounts received by that person as compensation for the injur-
4 ies from collateral sources, whether private, group, or governmental,
5 and whether contributory or noncontributory. Evidence of collateral
6 sources, other than a source that must by law or contract be repaid
7 and the death benefit paid under life insurance, shall be considered
8 by the trier of fact in determining the amount of an award, and shall
9 be considered by the court in determining if an award is excessive.
10 The trier of fact shall be informed of the tax implications of an
11 award of damages. The court may take into account the value of the
12 person's rights to coverage exhausted or depleted by payment of these
13 collateral benefits by adding back a reasonable estimate of their
14 probable value, or by earmarking and holding for possible periodic
15 payment under AS 09.17.040 that amount of the award that would other-
16 wise have been deducted, to see if the impairment of the person's
17 rights actually takes place in the future.

8 (2) a member of the board of directors of a public or
9 nonprofit hospital, or a member of a citizen's advisory board of any
10 hospital;
11 (3) a member of a school board of a school district;
12 (4) a member of the governing body, a commission, or a
13 citizen's advisory committee of a municipality of the state;
14 (5) a member of the board of directors of an electric or
15 telephone cooperative organized under AS 10.25.

16 * Sec. 10. AS 09.17.070 is repealed and reenacted to read:

17 Sec. 09.17.070. COLLATERAL BENEFITS. (a) A party defending
18 against a claim may introduce evidence of amounts received or to be
19 received by the claimant as compensation for the same injury from the
20 following collateral sources:
21 (1) 42 U.S.C. 301 - 1397 (Social Security Act);
22 (2) state or federal income disability or worker's compen-
23 sation benefits;
24 (3) health, sickness, accident, or income insurance; or
25 (4) a contract or agreement to pay medical, hospital,
26 dental, or other health care services.
27 (b) If the party defending against the claim elects to introduce
28 evidence under (a) of this section, the claimant may introduce evi-
29 dence of the amount that the claimant has
1 (1) incurred in actual attorney fees in pursuing the civil
2 action; and
3 (2) paid or contributed to secure the right to an insurance
4 benefit, contract, or agreement introduced as evidence by the party
5 defending against the claim.
6 (c) A source of collateral benefits introduced under (a) of this
7 section may not recover from the claimant an amount paid as compen-
8 sation for the injury, and may not be subrogated to the rights of the
9 claimant against the party defending against the claim.

18 * Sec. 12. AS 09.30.070(a) is amended to read:

19 (a) The rate of interest on judgments and decrees for the payment
20 of money is sight [10.5] percent a year, except that a judgment or
21 decree founded on a contract in writing, providing for the payment of
22 interest until paid at a specified rate not exceeding the legal rate
23 of interest for that type of contract, bears interest at the rate
24 specified in the contract if the interest rate is set out in the
25 judgment or decree.

26 * Sec. 13. AS 09.30.070 is amended by adding a new subsection to read:

27 (c) Prejudgment interest may not be awarded for future economic
28 or noneconomic damages.

10 * Sec. 11. AS 09.30.070 is amended by adding a new subsection to read:

11 (c) Prejudgment interest may not be awarded for future economic
12 or noneconomic damages.

29 * Sec. 14. AS 09.55.580(c) is amended to read:

1 (c) Except as provided in (a) of this section, in [IN] fixing
2 the amount of damages to be awarded under this section, the court or
3 jury shall consider all the facts and circumstances and from them fix
4 the award at a sum which will fairly compensate for the injury result-
5 ing from the death. In determining the amount of the award, the court
6 or jury shall consider but is not limited to the following:

7 (1) deprivation of the expectation of pecuniary benefits to
8 the beneficiary or beneficiaries, without regard to age thereof, that
9 would have resulted from the continued life of the deceased and with-
10 out regard to probable accumulations of what the deceased may have
11 saved during the lifetime of the deceased;

12 (2) loss of contributions for support;

13 (3) loss of assistance or services irrespective of age or
14 relationship of decedent to the beneficiary or beneficiaries;

15 (4) loss of consortium;

16 (5) loss of prospective training and education;

17 (6) medical and funeral expenses.

* Sec. 15. AS 09.55.580 is amended by adding a new subsection to read:

(g) The amount awarded by the court or jury for nonpecuniary damages may not exceed \$50,000.

* Sec. 16. AS 09.60.010 is amended to read:

Sec. 09.60.010. COSTS ALLOWED PREVAILING PARTY. The supreme court shall determine by rule or order the costs, if any, that may be allowed a prevailing party in a civil action. Unless specifically authorized by statute or by agreement between the parties, attorney fees may not be awarded to a party in a civil action for personal injury, death, or property damage related to or arising out of fault, as defined in AS 09.17.900 [UNLESS THE CIVIL ACTION IS CONTESTED WITHOUT TRIAL, OR FULLY CONTESTED AS DETERMINED BY THE COURT].

* Sec. 17. AS 09.65 is amended by adding a new section to read:

Sec. 09.65.096. CIVIL LIABILITY OF HOSPITALS FOR NONEMPLOYEES.

(a) A hospital that is required to provide services by AS 18.20 or regulations implementing that chapter, or that is subject to regulation with respect to the provision of services, is not, solely for that reason, liable for civil damages as a result of an act or omission in administering those services by a health care provider who is not an employee of the hospital.

(b) Compliance with the standards of a public or private licensing or accreditation agency with respect to provision of services, or adoption by the hospital of bylaws or regulations governing provision of services, may not be construed as an assumption of civil liability by the hospital for the acts or omissions of a health care provider who is not an employee of the hospital.

(c) A hospital is not, solely for reason that a health care provider was the actual, apparent, or implied agent of the hospital, liable for civil damages caused by the acts or omissions of a health care provider who is not the hospital's employee, if the hospital provides notice that the health care provider is an independent com-

tractor. The notice required by this subsection must be posted conspicuously in all admitting areas of the hospital, published at least annually in a newspaper of general circulation in the area, and must be in substantially the following form:

Notice of Limited Liability

The following health care providers are independent contractors and are not employees of the hospital:

(List specific health care providers)

The hospital is responsible for exercising reasonable care in granting staff privileges to practice in the hospital, for reviewing these privileges on a regular basis, and for taking appropriate steps to revoke or restrict privileges in appropriate circumstances. The hospital is not otherwise liable for the acts or omissions of a health care provider who is an independent contractor.

(d) This section does not preclude liability for civil damages that are the proximate result of the hospital's own negligence or intentional misconduct.

(e) In this section,

(1) "health care provider" has the meaning given in AS 18.23.070, except that it does not include a hospital or an employee of the hospital;

(2) "hospital" has the meaning given in AS 18.20.130 and includes a governmentally owned or operated hospital.

* Sec. 18. AS 21.06.110 is amended to read:

Sec. 21.06.110. DIRECTOR'S ANNUAL REPORT. As early in each calendar year as is reasonably possible the director shall prepare and deliver an annual report to the legislature and the commissioner, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in Alaska, with such summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose business was closed during the year, the cause of the closing, and the amount of ascertainable assets and liabilities of each closed business;

* Sec. 12. AS 21.06.110 is amended to read:

Sec. 21.06.110. DIRECTOR'S ANNUAL REPORT. As early in each calendar year as is reasonably possible the director shall prepare and deliver an annual report to the legislature and the commissioner, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in Alaska, with such summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose business was closed during the year, the cause of the closing, and the amount of ascertainable assets and liabilities of each closed business;

(3) the name of each insurer against which delinquency or similar proceedings were instituted, and a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipts and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance, or the office of director;

(7) other pertinent information and matters the director considers proper;

(8) an analysis of medical malpractice insurance rate changes occurring as a result of court decisions in the state involving personal injury or death.

(3) the name of each insurer against which delinquency or similar proceedings were instituted, and a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipts and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance, or the office of director;

(7) other pertinent information and matters the director considers proper;

(8) an analysis of medical malpractice insurance rate changes occurring as a result of court decisions in the state involving personal injury or death;

(9) an analysis of liability insurance claims that were closed following a civil action, that

(A) establishes a statistical data base for comparing the annual percentage change in the number and amount of claims;

(B) determines the number and dollar amount of claims closed, by year incurred; and

(C) compares the percentage change in direct premiums written;

(10) an analysis of changes in the incomes of physicians licensed under AS 08.64 occurring as a result of court decisions in the state involving personal injury or death.

* Sec. 19. AS 47.37.170(g) is repealed and reenacted to read:

(g) A person may not bring an action for damages against a peace officer, or members of the emergency service patrol, based on the performance or failure to perform a duty imposed under this section, unless the act or omission of the peace officer or member of the emergency service patrol is grossly negligent, reckless or intentional.

18 * Sec. 20. ~~AS 09.17.010(c), 09.17.040(c) and AS 09.55.548 are repealed.~~

19 * Sec. 21. REPORT. The Department of Commerce and Economic Develop-
20 ment, with the cooperation of all state agencies, shall report to the
21 legislature by the 30th day of the Second Session of the Seventeenth Alaska
22 State Legislature on closed insurance claims and insurance company fi-
23 nances. The report must consist of

- 24 (1) a study of closed insurance claims to identify
- 25 (A) the extent to which the legal system has or has not
- 26 been the cause of dramatic liability insurance increases or decreases
- 27 and coverage reduction in crisis lines in the state;
- 28 (B) how victims are faring under the present system;
- 29 (C) what the various specific tort reform measures have
- 1 actually accomplished; and
- 2 (D) if the passage of this Act has resulted in a measurable
- 3 decrease in insurance rates in the state;
- 4 (2) a study of insurance company finances to determine the
- 5 extent to which
- 6 (A) dramatic liability insurance rate increases and cover-
- 7 age limitations in the state are, or are not, cost-justified in re-
- 8 lation to awards, settlements, and relevant court decisions in the
- 9 state involving personal injury, death, or property damage based on
- 10 fault; and
- 11 (B) legislative or regulatory actions affecting the tort
- 12 system in the state are necessary to resolve the state's liability
- 13 insurance rate increases.

21 * Sec. 13. ~~AS 09.10.035(b), 09.17.040(c), and AS 09.55.548 are~~
22 ~~repealed.~~

23 * Sec. 14. REPORT. The Department of Commerce and Economic Develop-
24 ment, with the cooperation of all state agencies, shall report to the
25 legislature by the 30th day of the Second Session of the Seventeenth Alaska
26 State Legislature on closed insurance claims and insurance company fi-
27 nances. The report must consist of

- 28 (1) a study of closed insurance claims to identify
- 29 (A) the extent to which the legal system has or has not
- 1 been the cause of dramatic liability insurance increases or decreases
- 2 and coverage reduction in crisis lines in the state;
- 3 (B) how victims are faring under the present system;
- 4 (C) what the various specific tort reform measures have
- 5 actually accomplished; and
- 6 (D) if the passage of this Act has resulted in a measurable
- 7 decrease in insurance rates in the state;
- 8 (2) a study of insurance company finances to determine the
- 9 extent to which
- 10 (A) dramatic liability insurance rate increases and cover-
- 11 age limitations in the state are, or are not, cost-justified in re-
- 12 lation to awards, settlements, and relevant court decisions in the
- 13 state involving personal injury, death, or property damage based on
- 14 fault; and
- 15 (B) legislative or regulatory actions affecting the tort
- 16 system in the state are necessary to resolve the state's liability
- 17 insurance rate increases.

Deletions this side

14 * Sec. 22. AS 09.30.070(c) as added by sec. 13 of this Act, has the
15 effect of amending Alaska Rule of Civil Procedure 68 by providing that
16 prejudgment interest may not be awarded for future economic or noneconomic
17 damages.

18 * Sec. 23. AS 09.60.010 as amended by sec. 16 of this Act, has the
19 effect of amending Alaska Rule of Civil Procedure 82 by prohibiting the
20 award of attorney fees in a civil action for personal injury, death, or
21 property damage, unless allowed by statute or by agreement of the parties.

22 * Sec. 24. APPLICABILITY. This Act applies to all causes of action
23 accruing on or after the effective date of this Act.

24 * Sec. 25. This Act takes effect immediately under AS 01.10.070(c).

Additions this side

18 * Sec. 15. AS 09.30.070(c), as added by sec. 11 of this Act, has the
19 effect of amending Alaska Rule of Civil Procedure 68 by providing that
20 prejudgment interest may not be awarded for future economic or noneconomic
21 damages.

22 * Sec. 16. APPLICABILITY. (a) This Act applies to all causes of
23 action for damages resulting from an act or omission occurring on or after
24 the effective date of this Act.

25 (b) AS 09.17.070(c), as added by sec. 10 of this Act, applies to a
26 contract or agreement entered into on or after the effective date of this
27 Act.

28 * Sec. 17. This Act takes effect immediately under AS 01.10.070(c).

C.4

MEMORANDUM

February 17, 1989

SUBJECT: Civil Actions - HB 166
TO: Representative Sam Cotten
FROM: Michael F. Ford
Legislative Counsel

The following is a sectional analysis of HB 166:

Section 1 - Findings and purpose.

Section 2 - Requires that an action for personal injury, death, or property damage be brought within six years of the date of injury, if caused by a product or by construction, or within six years of the last act alleged to be the cause of the injury. Periods of disability, such as minority, incompetency, or imprisonment do not extend the six year period. This section does not apply if the personal injury, death, or property damage was caused intentionally, or if another shorter period of limitation applies.

Section 3 - Removes actions for personal injury, death, or property damage, from the existing two year statute of limitations.

Section 4 - Requires that an action for personal injury, death, or property damage be brought within two years of the time the person had the right to bring the action. The two year period is not extended for any period of disability, such as minority, incompetency, or imprisonment. The section does not apply if a shorter period of limitation is imposed.

Section 5 - Requires that clear and convincing evidence of malice, bad motive, or reckless indifference to the interests of another exist before punitive damages may be awarded.

Section 6 - Prohibits a person from recovering damages for personal injury or death if the injury or death occurred while the person was committing a crime and the person has been convicted of the crime. Crime includes a felony or a misdemeanor.

Section 7 - Provides that a person who commits a crime that results in personal injuries to that person is not prevented from recovering damages for personal injury or death, if the person liable was also engaged in the commission of a crime and has been convicted of the crime. Also defines the term "crime", to include a felony or a misdemeanor.

Section 8 - Requires that if a portion of a judgment is owed to an attorney under a contingent fee agreement, that portion must be reduced to a present value and paid in a lump sum, rather than as a part of periodic payments ordered by the court.

Section 9 - Requires that the court include an amount for inflation, when ordering that future damages be paid by periodic payments.

Section 10 - Prohibits recovery of damages for personal injury, death, or property damage caused by an act or omission within the official duties of a member of the board of directors or an officer of a public corporation, or electric or telephone cooperative, unless the act or omission constituted gross negligence.

Section 11 - Allows a person to only recover damages that are in excess of compensation received from other sources, such as private or government insurance. Also requires the court or jury to be informed of the tax implications of an award of damages.

Section 12 - Lowers the legal rate of interest that may be awarded on judgments from 10.5% to eight percent, unless otherwise agreed by contract.

Section 13 - Prohibits the award of prejudgment interest for future economic or noneconomic damages.

Section 14 - Technical amendment.

Section 15 - Prohibits an award of nonmonetary damages in excess of \$50,000, in a wrongful death action.

Representative Sam Cotten
Page 3
February 17, 1989

Section 16 - Prohibits the court from awarding attorney fees in a civil action for personal injury, death, or property damage, unless specifically authorized by statute or by agreement of the parties.

Section 17 - Limits the liability of a hospital for civil damages caused by a person who is not an employee. Requires the hospital to post notice that certain individuals are not employees. Provides that the limitation does not apply to liability based on the hospital's own negligence or intentional misconduct. Adds certain definitions.

Section 18 - Requires the director of the division of insurance to annually report to the legislature regarding medical malpractice insurance rate changes occurring as a result of certain court decisions.

Section 19 - Limits the right of a person to bring an action against a peace officer or member of the emergency service patrol when taking an intoxicated person into custody, unless the act or commission was grossly negligent, reckless or intentional.

Section 20 - Repeals (1) a limit on recovery of noneconomic damages contained in AS 09.17.010(c), (2) an exception to the award of future damages contained in AS 09.17.040(c), and (3) a section regarding consideration of collateral benefits in a medical malpractice action contained in AS 09.55.548.

Section 21 - Requires the Department of Commerce and Economic Development to report to the legislature regarding the effect of certain insurance claims on the civil justice system.

Section 22 - Notice of amendment to the civil rules of court.

Section 23 - Notice of amendment to the civil rules of court.

Section 24 - Applicability.

Section 25 - Effective date.

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wherever possible. In contract, not only do the parties share this wish to avoid causation litigation, but also the desire to avoid all litigation. Since the parties shape their obligations, they can define them in such a way that the issues for which causation have been used in tort litigation are resolved in the agreement itself. The promise makes clear which risks are being assumed by the promisor, to whom the obligation runs, and, often, for what damages the promisor is willing to be responsible.

Insurance, which is probably contractual only as a historical matter,¹¹² does not easily permit this avoidance. The definitional requirement that valid insurance cover only fortuitous risks forces the court to face causation issues in defining fortuity. In third-party insurance, the obligations of the insurer are defined by the duties of the insured and they encompass causation problems. Since insurers do not as a general practice want to assume very broad and comprehensive "all risks" liability in first party insurance, there will always be substantial litigation about what the coverage clauses of policies mean and whether the covered occurrence really produced the loss of the insured. These are the basic and unavoidable problems of insurance causation.

¹¹² For a discussion of the degree to which insurance is or ought to be thought of as contractual, see McDowell, *The Misrepresentation Defense in Insurance: A Problem for Contract Theory*, 10 CORN. L. REV. 513 (1984).

THE CAUSES OF THE MEDICAL MALPRACTICE CRISIS: AN ANALYSIS OF CLAIMS DATA AND INSURANCE COMPANY FINANCES

David J. Nye,* Donald G. Gifford,**
Bernard L. Webb,*** Marvin A. Dewar****

I. INTRODUCTION

When the President of the American College of Obstetricians and Gynecologists reported in February 1986 on the state of his profession, he chose Charles Dickens' opening words in *A Tale of Two Cities*. "It was the best of times, it was the worst of times," recited Dr. William Mixson.¹ On one hand, Mixson noted the significant advances in medical care for obstetrical patients and the reduced risks

* Associate Professor of Finance and Insurance, University of Florida College of Business. B.S. 1965, University of British Columbia, Ph.D. 1973, University of Pennsylvania.

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The authors conducted much of the research for this article as members of the professional staff of the Academic Task Force for Review of the Insurance and Tort Systems, an agency within the Executive Office of the Governor of the State of Florida. The Academic Task Force was established and funded by the Florida Legislature to study problems in affordability and availability of liability insurance, to determine their causes, and to report back to the legislature with recommendations for change in the insurance and tort systems (Tort Reform and Insurance Act of 1986, ch. 86-160, 1986 Fla. Laws 695). The interpretations of data contained in this article are those of the authors and do not necessarily reflect the conclusions of the Academic Task Force or its members.

The authors wish to express their appreciation to Marshall M. Ciseri, President of the University of Florida and Chairman of the Academic Task Force, and the other members of the Task Force for their support and encouragement. The authors also thank Executive Director Carl S. Hawkins, systems programmer Michael Kelly, research assistants Peggy Lyon and John Davis, and administrative secretary Norcen Fenner for their contributions to this manuscript.

¹ Mixson, *The Spring of Hope*, 67 OBSTETRICS & GYNECOLOGY J. AM. C. OBSTETRICIANS & GYNECOLOGISTS 153, 153 (1986).

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of infant mortality. On the other hand, reported Mixson, the professional liability of members of his profession had reached "crisis proportions."² Pregnant women in smaller communities in a number of states no longer had access to obstetrical services as a result of increased malpractice premiums.³

The effect of liability insurance problems on medical care has not been limited to obstetrics. One of a series of reports on the malpractice crisis completed by the General Accounting Office (GAO) for Congress stated that insurance costs for all physicians and hospitals increased from \$2.5 billion in 1983 to \$4.7 billion in 1985.⁴ Medical malpractice liability insurance problems also were highlighted in two reports issued by the Tort Policy Working Group established by the Attorney General of the United States.⁵

The state of Florida received particular attention as early as the fall of 1984 when an article in *Newsweek* magazine proclaimed: "The malpractice crisis . . . is alive and well and growing in Florida."⁶ A GAO study showed that Florida physicians had the highest malpractice premiums of six states studied, including both New York and California.⁷ Further, the increases in malpractice premiums from 1980 through 1986 were substantially higher in Florida than in other

2. *Id.* at 153-54.

3. H. Jonas, Representing the American College of Obstetricians and Gynecologists (Aug. 13, 1986) (statement prepared for *Hearings on H.R. 2695 Before the Subcomm. on Admin. Law and Gov't Relations, 99th Cong., 1st Sess. (1985)*; hearing was canceled and statement never delivered); cf. American College of Obstetricians & Gynecologists, News Release (Nov. 14, 1985) (statement by William T. Mixson, M.D., President, American College of Obstetricians and Gynecologists, on release of 1985 survey of 1,400 obstetricians and gynecologists, conducted in June and July of 1985) (availability of obstetrical care is likely to suffer because family physicians in some communities can no longer afford liability insurance to cover obstetrics and because of increasing number of physicians giving up obstetrics and cutting down on high risk obstetrics) (unpublished, copy on file at *Georgetown Law Journal*).

4. UNITED STATES GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: A FRAMEWORK FOR ACTION 2 (1987) [hereinafter GAO, FRAMEWORK FOR ACTION].

5. TORT POLICY WORKING GROUP, AN UPDATE ON THE LIABILITY CRISIS 2 (1987); TORT POLICY WORKING GROUP, REPORT OF THE TORT POLICY WORKING GROUP ON THE CAUSES, EXTENT AND POLICY IMPLICATIONS OF THE CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY 2 (1986).

6. Press, Prout & McDaniel, *How the Doctors Spell Relief*, *Newsweek*, Sept. 17, 1984, at 73.

7. UNITED STATES GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: SIX STATE CASE STUDIES SHOW CLAIMS AND INSURANCE COSTS STEADILY RISE DESPITE REFORMS 16 (1986). The rates compared between states included those for Florida outside of the Miami and Fort Lauderdale metropolitan areas, and for New York outside of the New York City and Long Island areas. Rates for these metropolitan areas in each state often are nearly double those in the remainder of the state.

locales.⁸ By 1987, the American Medical Association (AMA) had declared south Florida to be "the Beirut" of the medical malpractice crisis.⁹ The crisis became life-threatening when neurosurgeons and other physicians stopped work to protest increased malpractice premiums; as a result, some emergency rooms closed and others curtailed services.¹⁰ The *Palm Beach Post* recounted the story of a patient rendered brain-damaged and paralyzed because of the lack of neurosurgical care.¹¹

In Florida and throughout the nation, the medical malpractice crisis has led to finger-pointing. Physicians have blamed lawyers, and lawyers have blamed the insurance industry and physicians. The president of the local medical association in Miami attributed the crisis to "some very clever and avaricious attorneys that have so perverted the justice system as to take the words [sic] 'justice' out of the system."¹² President Ronald Reagan and Attorney General Edwin Meese joined the chorus of those pointing the finger at trial lawyers and the court system.¹³ Trial lawyers and consumer groups counterattacked. The President of the Association of Trial Lawyers of America claimed: "The insurance industry itself has created the situation and

8. *Id.* at 15. The highest percentage increases in premiums of the six states surveyed occurred in New York, North Carolina, and Florida. *Id.*

9. Ver Berkmoes, *South Florida faces 'semi-battlefield condition' in care*, *AM. MED. NEWS*, July 17, 1987, at 2.

10. See Nordheimer, *Doctors Withhold Services in Protest on Insurance*, *N.Y. TIMES*, Dec. 10, 1986, at A25, col. 1; *Florida Hospitals Curtail Services As Doctors Protest Insurance Costs*, *N.Y. TIMES*, Jan. 2, 1987, at D14, col. 1; *Hospitals in Florida Cut Certain Services As Protest Continues*, *N.Y. TIMES*, Jan. 3, 1987, at 8, col. 3.

11. The newspaper reported that a patient with a severe head injury lay comatose for eight hours while doctors searched for a local neurosurgeon to accept the patient; some neurosurgeons refused to treat patients until the legislature took action to reduce malpractice liability. Ellicott, *Malpractice answer would come too late for stunned victim*, *Palm Beach Post*, Sept. 12, 1987, at 1A, 11A. In another case, a 36-year-old tourist suffering from a broken neck and wrist waited six hours until the hospital located a surgeon who would treat her. Truesdell & Robb, *Wreck Victim Gets MD—6 Hours Later*, *Miami Herald*, June 11, 1987, at A1, col. 1.

12. Dr. Bruce W. Weissman, President of Dade County Medical Association, Testimony Before the Academic Task Force for Review of the Insurance and Tort Systems, vol. 1, at 15-16 (Miami, Fla., Feb. 3, 1987).

13. See Molotsky, *Reagan Reiterates Support for Liability Suit Limits*, *N.Y. TIMES*, May 31, 1986, at 28, col. 1. The American Tort Reform Association, an organization of business and professional groups before whom Reagan spoke, asserted: "The liability crisis is about 75% the responsibility of lawyers and judges. . . ." American Tort Reform Ass'n, Questions and Answers on Civil Justice Reform, Question 16 (undated pamphlet) (copy on file at *Georgetown Law Journal*). Similarly, Mortimer B. Zuckerman, Chairman and Editor in Chief of *U.S. News & World Report* blamed the civil justice system: "An epidemic of costly litigation is sweeping the country, and the time to halt it is now." Zuckerman, *The National Lottery*, *U.S. NEWS & WORLD REP.*, Jan. 27, 1986, at 80. Zuckerman attributed the crisis to personal injury awards that are "out of touch with reality." *Id.*

now seeks to profit from it."¹⁴ Ralph Nader charged that insurers were "price-gouging the public."¹⁵ A year later, the succeeding president of the trial lawyers' association asserted: "Study after study has found that the cause of malpractice litigation is simply malpractice — incompetent or careless doctors harming innocent patients."¹⁶ J.B. Spence, a well known plaintiffs' medical malpractice attorney, summed it up by stating that "the insurance industry in this country has a gun to the head of the doctors [and] the doctors, in turn, have a gun to the head of legislatures."¹⁷

In the midst of this cacophony of competing claims, the Florida legislature established a task force to study the problem of the lack of affordable and available liability insurance, to determine its causes, and to report back to the legislature with recommendations for change in the state's insurance and tort systems.¹⁸ Unlike similar groups in other states, the task force did not consist of representatives of the major conflicting interest groups;¹⁹ instead, its five members included the presidents of the three major Florida universities, and two businessmen with distinguished public service backgrounds.²⁰

14. Perlman, *President's Page*, TRIAL, Jan. 1986, at 5; see ASSOCIATION OF TRIAL LAWYERS OF AM., THE INSURANCE CRISIS: A STUDY IN DECEPTION 2 (1986) ("insurance company accounting methods, business practices, and cyclical influences — not the justice system — have been the cause of the recent crisis in the liability insurance marketplace").

15. Housatz, *Nader Charges Insurers with Price-Gouging*, WASH. POST, Jan. 7, 1986, at D1, col. 6; J. Robert Hunter, former Federal Insurance Administrator in the Carter and Ford Administrations and president of the National Insurance Consumer Organization, charged that the liability insurance crisis is primarily an insurance problem caused by "cash flow underwriting." Hunter & Bozilleri, *The Liability Insurance Crisis: Insurers Put the Squeeze on Consumers*, TRIAL, Apr. 1986, at 43.

16. Pavalon, *Medical Malpractice*, NAT'L J., July 20, 1987, at 20, col. 3; see UNITED STATES GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: NO AGREEMENT ON THE PROBLEMS OR SOLUTIONS 27 (1986) (summary of trial lawyers' view that fundamental cause of medical malpractice claims is medical carelessness); see also Lee, *Medical Board Urges Tougher Licensing to Cut Insurance Costs*, MIAMI HERALD, July 12, 1987, at B4, col. 1 (executive director of Florida medical board suggests weeding out unskilled doctors to address malpractice problem).

17. J.B. Spence, Testimony Before Academic Task Force for Review of the Insurance and Tort Systems, vol. II, at 136 (Miami, Fla., Feb. 3, 1987).

18. Tort Reform and Insurance Act of 1986, ch. 86-160, 1986 Fla. Laws 695.

19. Past commissions have consisted of representatives of those interest groups affected most directly by the tort and insurance systems — trial lawyers, doctors, insurance industry spokesmen, and businesses. See, e.g., Executive Office of Consumer Affairs & Business Regulation, State of Mass., Liability in Massachusetts: Toward a Fairer System, Report of the Governor's Task Force on Liability Issues 2 (Dec. 1986) (unpublished, copy on file at Georgetown Law Journal); State of Fla., Report of the Governor's Task Force on Emergency Room and Trauma Care (Mar. 1987) (unpublished, copy on file at Georgetown Law Journal); Legal Action Task Force, State of Wash., Report of the Professional Liability Insurance Subcommittee of the Legal Action Task Force 2 (Dec. 1986) (unpublished, copy on file at Georgetown Law Journal).

20. Members of the Florida Academic Task Force for Review of the Insurance and

The Florida task force also differed from other groups because it had a sufficient budget to hire an extensive staff consisting of academics and other professionals with expertise in law, insurance, finance, economics, and medicine.

This task force, the Academic Task Force for Review of the Insurance and Tort Systems, originally was established to deal with liability problems in all areas. In July of 1987, however, Governor Robert Martinez of Florida asked the task force to focus specifically on the medical malpractice crisis and to expedite the completion of this portion of the project. The four coauthors of this article were members of the research team investigating the causes of the dramatic increase in the cost of medical malpractice insurance.

This article evaluates the competing claims charging responsibility for the tremendous increases in the cost of medical liability insurance. Part II documents the dramatic increases in physicians' insurance premiums and how these increases affected both patient health care costs and physicians' income.

The third part evaluates the relative contribution of four potential causes of higher premiums: (1) increased loss payments; (2) excessive insurance company profits; (3) the insurance industry underwriting cycle; and (4) the risk classification system used by insurers for rating and pricing purposes. The primary cause of increased malpractice premiums measured over the last nine years is found to have been the substantial increase in loss payments to claimants. Excessive insurance industry profits are not found to be a cause of increased malpractice premiums; contrary to the claims of consumer advocates, insurance company profits are roughly equivalent to those of other American industrial and financial corporations. The third part also evaluates the role of the so-called insurance industry "underwriting cycle" in the recent medical malpractice rate increases and concludes that the underwriting cycle contributed to the suddenness and the timing of price increases in malpractice insurance during the period 1983 through 1987. Over the course of the entire underwriting cycle, however, it was the increase in paid claims that caused higher premiums for doctors. Finally, part III examines the insurance industry practice of dividing physicians into risk classes by specialty and geographical area for rating and pricing purposes. These risk classification procedures are found to exacerbate affordability problems for physicians practicing in high-risk specialties or in high-risk metropolitan areas.

Tort Systems include the Chairman, Marshall M. Criser, President of the University of Florida; Edward Thaddeus Foote II, President of the University of Miami; Preston H. Haskell, President of The Haskell Company, Architects/Engineers/Contractors; P. Scott Linder, Chairman of Linder Industrial Machinery Company; Dr. Bernard F. Shger, President of Florida State University.

The fourth part presents a uniquely comprehensive analysis of medical malpractice closed claims. This analysis interprets data from a major jurisdiction collected over a twelve-year period between 1975 and 1986 by the Florida Department of Insurance.²¹ The analysis of medical malpractice payments published elsewhere has relied either on selective insurance industry data voluntarily provided,²² or on a closed claims survey for a one-year period.²³ The data presented in this article enabled the authors to establish trends in the frequency and amounts of paid losses during the period corresponding to the tremendous increase in medical malpractice premiums.

The closed claims analysis shows that the frequency of medical malpractice paid claims in Florida, when adjusted for the increase in population, has increased only slightly since 1975.²⁴ The size of loss payments, however, has increased more dramatically and is a substantially more important factor in the overall increase in paid claims.²⁵ The analysis shows that the average cost of a paid claim has increased since 1975 at an average compound rate of 14.8% per year. Significant variations exist among medical specialties and between various geographic areas in both the frequency and the severity of loss payments, according to the closed claims data. Specialties such as obstetrics are affected disproportionately by medical malpractice claims and unusually high amounts of paid claims,²⁶ as are certain metropolitan areas such as Miami, Fort Lauderdale, and other urban areas of south Florida.²⁷ The closed claims analysis further shows that physicians with two or more paid claims accounted for nearly one-half of the amount of paid claims in Florida during the period 1975 through 1986, thus lending support to the argument that more professional regulation of physicians is required if the malpractice crisis is to be ameliorated.

II. COST TRENDS FOR MEDICAL LIABILITY INSURANCE

The cost of medical malpractice insurance has increased sharply in

recent years. This part measures the extent of price changes in medical malpractice insurance during the past five years; subsequent parts explore the potential causes of such price increases. The price of medical malpractice insurance varies dramatically among states, and even within areas of a single state, depending upon the past and expected claims experience within a locale.

This part first compares medical malpractice rates in Florida during the recent past with those in other states. It then shows the dramatic upward trends in malpractice rates for various medical specialties within Florida during the past five years. Changes in the price of medical liability insurance are compared with changes in the Consumer Price Index, and with various indices showing price increases for medical services. Finally, this part explores the relationship between changes in insurance rates and physicians' income by tracking changes in the percentage of the physicians' gross incomes that are spent on malpractice insurance.

A. Comparison Between Malpractice Rates In Florida And In Other States

Malpractice insurance rates in Florida are among the highest in the nation — if not the highest. Table I compares the rates charged in Florida by the state's largest malpractice insurer with those charged by the largest insurers for five other states for selected specialties, as of January 1, 1986. The Florida rates are those charged in areas of the state outside the south Florida metropolitan areas around Miami and Fort Lauderdale (Dade and Broward Counties). As discussed below, malpractice rates in these urban areas are precipitously higher than in the rest of the state.

21. Analysis of Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

22. E.g., P. DANZON, *THE FREQUENCY AND SEVERITY OF MEDICAL MALPRACTICE CLAIMS* (1982); DANZON, *The Frequency and Severity of Medical Malpractice Claims: New Evidence*, 49 LAW & CONTEMP. PROBS. 57 (Spring 1986).

23. E.g., UNITED STATES GEN. ACCOUNTING OFFICE, *MEDICAL MALPRACTICE: CHARACTERISTICS OF CLAIMS CLOSED IN 1981*, at 2 (1987) [hereinafter GAO, *CLAIMS CLOSED IN 1984*] (GAO analyzed data from random sample of claims closed in 1984).

24. See *infra* part IV-A.

25. See *infra* part IV-B.

26. See *id*.

27. See *id*.

TABLE 1

MEDICAL MALPRACTICE PREMIUMS FOR SELECTED STATES:^{*}
JANUARY 1, 1986

Specialty	Florida [*]	Arkansas	California [*]	Indiana [*]	New York [*]	North Carolina
General practice (minor surgery)	\$10,118	\$ 1,907	\$10,024	\$ 2,328	\$ 9,220	\$ 2,760
Internal medicine (minor surgery)	10,118	1,907	5,924	2,328	7,233	2,760
General surgery	35,791	6,063	28,576	7,760	20,642	8,896
Anesthesiology	11,837	5,192	20,192	7,760	13,598	7,924
Obstetrics/ gynecology	59,537	9,910	42,928	11,380	35,133	16,901
Orthopedic surgery	47,667	7,985	33,632	10,605	36,472	11,812
Neurosurgery	75,367	12,612	37,984	11,380	43,019	18,595

SOURCE: UNITED STATES GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: SIX STATE CASE STUDIES SHOW CLAIMS AND INSURANCE COSTS STILL RISE DESPITE REFORMS (1986).

NOTES:

*Rates are those applicable to the state's leading insurer of physicians for the predominately purchased coverage limits and policy form for the rating territory in which there was the greatest total number of physicians insured.

*Rates applicable to entire state except for Dade and Broward Counties.

*Rates applicable to south California.

*Includes surcharge rate to participate in the Patient's Compensation Fund.

*Rates applicable to entire state except for Nassau, Suffolk, Bronx, Kings, Queens, Richmond, Rockland, Sullivan, New York, Orange, Ulster, and Westchester Counties.

B. Increases In Malpractice Insurance Rates In Florida

The cost of medical malpractice liability insurance in Florida has increased dramatically during the last eight years, with the largest share of this increase coming during the past two years. Both the absolute cost of malpractice insurance and the amount of price increases during the past five years vary greatly among medical specialties, and between south Florida physicians and physicians located elsewhere in the state. Table 2 shows the premiums for selected medical specialties from January 1, 1983, through July 1, 1987. The premiums listed are weighted averages of the rates charged by the three major Florida insurers: St. Paul Fire and Marine Insurance Company (abbreviated STP in the table), Florida Physicians Insurance Company (FPIC), and Physicians Protective Trust Fund (PPTF). The weights used in the calculations were the number of doctors insured by each company as of July 1, 1987.

TABLE 2

**MEDICAL MALPRACTICE INSURANCE RATES IN FLORIDA FOR SELECTED
 SPECIALTIES: 1983-1987**

Specialty	1-1-83	1-1-84	1-1-85	1-1-86	1-1-87	7-1-87
Family practitioners /no surgery						
Dade/Broward	\$1,310	\$5,368	\$7,206	\$11,806	\$15,123	\$15,515
Rest of state	3,123	3,654	4,825	7,147	9,122	10,247
Internal medicine /minor surgery						
Dade/Broward	7,825	9,738	11,179	20,080	25,511	30,442
Rest of state	5,606	6,867	9,172	11,815	5,075	16,058
Emergency medicine /no major surgery						
Dade/Broward	9,777	15,100	22,925	36,471	47,925	58,304
Rest of state	6,992	10,305	15,306	21,105	28,175	30,718
General surgery						
Dade/Broward	21,971	27,538	38,483	59,893	78,918	95,875
Rest of state	15,705	18,718	25,664	35,958	47,154	50,740
Anesthesiology						
Dade/Broward	23,919	27,538	38,483	55,915	73,623	88,838
Rest of state	17,061	18,718	25,664	33,317	43,942	47,021
Orthopedic surgery						
Dade/Broward	27,073	33,380	47,863	79,785	105,167	130,817
Rest of state	19,355	23,008	31,905	47,893	61,205	69,314
Obstetrics						
Dade/Broward	30,433	38,051	57,218	99,702	131,360	165,320
Rest of state	21,679	26,498	38,158	59,849	78,979	87,512
Neurological surgery						
Dade/Broward	37,569	49,787	71,967	115,548	152,525	192,420
Rest of state	27,285	31,180	49,974	70,423	93,100	102,339

SOURCE: Calculated from rates provided by the Florida Department of Insurance.

NOTE: Figures are weighted averages of Florida insurers' premium rates. The rates shown are those for a claims made malpractice policy with limits of \$1 million per occurrence and \$1 million aggregate at the companies' rates in effect on January 1 of the year indicated. The rates for July 1, 1987 are also shown.

Table 2 illustrates both tremendous increases in malpractice premiums for Florida physicians — for example, an increase of nearly \$155,000 for a neurosurgeon practicing in Miami — and considerable variations in the cost of insurance among various medical specialties and between physicians practicing in urban south Florida and elsewhere in the state. These differences appear most dramatically in the indices displayed in table 3 and in table 4. Table 3 allows comparison of medical malpractice premium rates among various specialties and comparisons over time from January 1, 1983, through July 1, 1987, for all Florida counties except Dade and Broward. The basis of "100" for this index is the 1983 premium for a family physician who performs no surgery and who practices outside of Dade and Broward Counties. For example, the entry of "329" for the "family physician/no surgery" listed in the 7-1-87 column indicates that on July 1, 1987, a physician in that risk class was paying a premium that was 329% of the 1983 premium, which represents an increase of 229%. Similarly, a comparison among specialties shows that in 1983 the rate for neurosurgeons in Florida counties other than Dade and

Broward was 87.4% of the premium rate for family physicians. Table 4 makes the same comparison of premiums for physicians practicing in Dade and Broward Counties, once again using the 1983 premium for a family physician who practices outside of Dade and Broward Counties as an index base of "100."

The indices in tables 3 and 4 show: (1) rates have increased sharply since 1983; (2) rates have increased more for the high-rated specialties in both rating territories than for the low-rated specialties; and (3) rates have increased more in Dade and Broward Counties than in

TABLE 3

INDICES OF MEDICAL MALPRACTICE INSURANCE RATES
FOR ALL FLORIDA COUNTIES EXCEPT DADE/BROWARD:
1983-1987

Specialty	1-1-83	1-1-84	1-1-85	1-1-86	1-1-87	7-1-87	Average Annual Increase (%)
Family Physician/ no surgery	100	117	154	229	292	329	26.9
Psychiatry/no electroconvulsive therapy	100	117	154	229	292	329	26.9
Radiology/diagnosis/ no surgery	100	117	154	229	292	329	26.9
Internal medicine/ no surgery	100	117	154	229	292	329	26.9
Pediatrics/no surgery	100	117	154	229	292	329	26.9
Radiology/diagnosis/ minor surgery	179	220	303	379	483	514	23.5
Internal medicine/ minor surgery	179	220	303	379	483	514	23.5
Family practice/ minor surgery	179	220	303	426	545	580	26.5
Surgery/ophthalmology	232	244	332	455	578	613	21.4
Surgery/urological	283	295	395	514	666	827	23.9
Emergency medicine/ no major surgery	224	330	490	685	902	984	34.4
Anesthesiology	546	599	822	1067	1407	1506	22.5
Surgery/otolaryngology/ no plastic	172	586	822	1151	1520	1625	28.1
General surgery	503	599	822	1151	1520	1625	26.4
Surgery/otolaryngology/ including plastic	546	654	913	1279	1685	1864	27.8
Cardiovascular surgery	576	717	1022	1523	2024	2219	31.0
Orthopedic surgery	620	737	1022	1534	2024	2219	29.0
Thoracic surgery	576	717	1022	1534	2024	2219	31.0
Obstetrics/gynecology	691	848	1222	1916	2529	2803	32.2
Neurological surgery	871	1104	1600	2255	2981	3277	30.3

SOURCE: Developed from medical malpractice rates for the top three insurers supplied by the Florida Department of Insurance.

NOTE: The base of 100 for this index is the 1983 premium for a family physician who performs no surgery and practices outside of Dade/Broward Counties.

the rest of the state. Even the low-risk classifications outside of Dade and Broward Counties experienced a sharp increase in malpractice insurance costs from 1983 to 1987.

Higher risk specialties outside of Dade and Broward Counties sustained greater average rate increases than lower risk specialties. For example, neurosurgeons in this area were subject to a 275% increase for the four and one-half period ending July 1, 1987. These increases reflect premiums at the end of the period almost four times higher than at the beginning of the period. The rates for obstetricians in

TABLE 4

INDICES OF MEDICAL MALPRACTICE INSURANCE RATES
FOR DADE/BROWARD COUNTIES: 1983-1987

Specialty	1-1-83	1-1-84	1-1-85	1-1-86	1-1-87	7-1-87	Average Annual Increase (%)
Family Physician/ no surgery	138	172	231	380	484	622	39.7
Psychiatry/no electroconvulsive therapy	138	172	231	380	484	622	39.7
Radiology/diagnosis/ no surgery	138	172	231	380	484	622	39.7
Internal medicine/ no surgery	138	172	231	380	484	622	39.7
Pediatrics/no surgery	138	172	231	380	484	622	39.7
Radiology/diagnosis/ minor surgery	251	312	454	643	817	975	35.2
Internal medicine/ minor surgery	251	312	454	643	817	975	35.2
Family practice/ minor surgery	251	312	454	713	911	1107	39.1
Surgery/ophthalmology	27	360	497	754	961	1157	32.4
Surgery/urological	391	430	590	876	1137	1354	31.8
Emergency medicine/ no major surgery	313	484	734	1168	1515	1867	48.7
Anesthesiology	767	882	1232	1790	2157	2815	31.8
Surgery/otolaryngology/ no plastic	665	865	1232	1918	2527	3060	40.1
General surgery	701	882	1232	1918	2527	3070	38.7
Surgery/otolaryngology/ including plastic	767	961	1370	2174	2859	3538	40.5
Thoracic surgery	804	1069	1533	2555	3367	4189	41.3
Orthopedic surgery	867	1069	1533	2555	3367	4189	41.9
Cardiovascular surgery	804	1069	1533	2555	3367	4189	41.3
Obstetrics/gynecology	974	1218	1832	3193	4206	5291	45.7
Neurological surgery	1203	1591	2400	3700	4884	6161	43.7

SOURCE: Developed from medical malpractice rates for the top three insurers supplied by the Florida Department of Insurance.

NOTE: The base of 100 for this index is the 1983 premium for a family physician who performs no surgery and practices outside of Dade/Broward Counties.

absolute dollars (as shown in table 2) are not quite as high as those for neurosurgeons, but the increase (30.4%) was even more precipitous, resulting in malpractice insurance costs slightly more than four times as high, on the average, in 1987 compared with 1983.

Table 4 shows that the increases in Dade and Broward Counties were even more extreme than for the remainder of the state. Family practitioners saw their malpractice insurance costs increase 350%, compared to 229% in the rest of the state. Rates for neurosurgeons increased 412% in south Florida and 275% in the rest of the state.

These rates of increase for obstetricians were 444% and 304%, respectively.

C. Trends In The Relationship Between Malpractice Premiums And Physicians' Income

The increase in malpractice insurance rates is only one aspect of the affordability issue. A \$30,000 increase in annual premiums means one thing in terms of affordability to a successful urban neurosurgeon with an annual net income exceeding \$300,000; it poses a different problem for the family physician making \$55,000 in a rural community. A closely related issue is whether increases in medical malpractice premiums are passed on to patients through increased medical costs or whether such premium increases actually reduce the physicians' net income.

I. Financial Effects On Physicians

As professional liability insurance costs increase, physicians must either shift their increased costs to consumers or suffer a relative decrease in their net earnings. The authors of this article, in their roles as research staff members for the Academic Task Force for Review of the Insurance and Tort Systems, surveyed fifteen hundred randomly selected Florida physicians.²⁸ The survey results indicate that the average (mean) medical liability premium for all physicians in policy year 1986/87 was \$23,747 and represented 11.6% of the physician's annual practice gross revenues. As demonstrated in table 5, both the absolute cost of premiums and premium costs as a percentage of gross income increased steadily throughout the study period (1971 to present). Information on net income was not obtained; consequently, no conclusion is possible from this data alone regarding the ability of physicians to shift the costs of increased liability premiums to consumers.

The survey updates, specifically for Florida, prior attempts to quantify the economic effects of rising liability insurance premiums on physicians. Reports from the early 1980s estimated that physicians spent between 2.9% and 3.7% of gross practice income on professional liability insurance.²⁹ By 1985 a survey by the American College

28. The survey of Florida physicians was prepared by the authors and sent to 1500 randomly selected members of the Florida Medical Association. Responses were obtained from 609 physicians, a response rate of 40.6%. Unless otherwise indicated, survey data are reported as the mean value for physicians responding to a given question.

29. FLORIDA MEDICAL ASS'N, MEDICAL MALPRACTICE POLICY GUIDEBOOK 16 (H.G. Manne ed. 1985) [hereinafter FMA, MALPRACTICE GUIDEBOOK]; see Kirchner, *Is Your Practice Begging for Money?*, MED. ECON., Nov. 12, 1984, at 214, 230 (random sample of U.S.

TABLE 5

ABSOLUTE RELATIVE COSTS OF LIABILITY INSURANCE

Specialty	Average Premium Amount	Premium Amount as % of Gross Revenues
All Physicians		
1971/72	\$ 4,645	3.6%
1981/82	8,915	5.4
1982/83	10,617	—
1983/84	12,613	7.0
1984/85	14,905	8.6
1985/86	19,232	9.7
1986/87	23,747	11.6
Surgical		
1971/72	3,891	4.2
1981/82	11,697	6.3
1982/83	15,266	7.8
1983/84	19,108	9.6
1984/85	23,288	12.1
1985/86	30,051	12.6
1986/87	37,730	14.7
OB/GYN		
1971/72	5,300	4.2
1981/82	11,983	5.5
1982/83	23,527	8.9
1983/84	26,709	10.3
1984/85	35,398	16.1
1985/86	48,819	18.5
1986/87	72,439	23.1

SOURCE: ACOG SURVEY, *supra* note 30.

of Obstetricians and Gynecologists (ACOG) indicated that liability premiums constituted 9.7% of average gross practice income for obstetricians and gynecologists throughout the country.³⁰

physicians reporting that in 1983 between 1.3% and 5.8% of gross practice income was spent on professional liability insurance).

30. AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS, PROFESSIONAL LIABILITY AND ITS EFFECT: REPORT OF A SURVEY OF ACOG'S MEMBERSHIP 19 (1985) [hereinafter ACOG SURVEY] (prepared for Needham Porter Novelli). The study surveyed members of the American College of Obstetricians and Gynecologists (ACOG), a subset of obstetricians and gynecologists who have completed specific training and treating requirements. It is possible that the income characteristics of ACOG members are different from the

As noted previously, significant differences in professional liability insurance costs exist between subgroups of the medical profession. The survey of Florida physicians shows that these variations are not limited to differences in absolute dollars, but also extend to substantial discrepancies in the percentages of physicians' gross revenues spent for liability insurance. For example, the mean liability premium reported for a physician practicing any kind of surgery was \$37,730 in 1986/87, representing 14.7% of gross practice revenues. Obstetricians and gynecologists present the most exaggerated example. In 1986/87, physicians in these specialties reported using 23.1% of gross practice revenues to pay an average of \$72,439 for liability coverage. In comparison to the 1985 ACOG study, which set the cost of insurance coverage as a percentage of gross income at 12.1% for Florida obstetricians and gynecologists,³¹ the survey results presented here reflect the most recent increases in cost of liability insurance.

2. Effects on Health Care Provider Fees

In response to increases in liability premiums, most physicians probably absorb some of the added cost and shift another portion of the increased costs to health care consumers via increased fees. Sixty-six percent of the physicians responding to the Florida physicians' survey indicated that they increased their fees in response to increased liability premiums or concern over medical malpractice claims. Of the subgroup of respondents increasing fees in response to premium increases, an average of 34% of their total fee increases during the study period were attributed to the effects of medical malpractice insurance costs. Previous studies also have documented fee increases in response to increased liability premiums. Zuckerman, using 1983 AMA survey data, reported that over 31% of physicians indicated increasing fees in response to rising liability premiums.³² The 1985 ACOG survey reported that over 94% of obstetricians and

income characteristics of obstetricians and gynecologists as a whole. If the additional qualifications of ACOG members translate into higher incomes than for other obstetricians and gynecologists, the percentage of gross income spent by members on professional liability insurance would be lower than for other gynecologists or obstetricians.

31. *Id.* Alternatively, the potential differences in income between members of the ACOG and other obstetricians and gynecologists, see *supra* note 30, would explain some of the increase in liability costs as a percentage of gross revenues. The obstetricians and gynecologists surveyed by the survey of Florida physicians probably included both ACOG and non-ACOG members. If the inclusion of non-ACOG obstetricians and gynecologists reduced the income average of the survey group, the portion of income spent on liability premiums would be expected to rise. This difference, however, would not be significant enough to account for substantial proportions of the increase in gross revenues paid for malpractice premiums.

32. Zuckerman, *Medical Malpractice: Claims, Legal Costs, and the Practice of Defensive Medicine*, 3 HEALTH AFF. 128, 131-32 (Fall 1984).

gynecologists in Florida stated that their professional fees increased due to the rising cost of liability insurance.³³

Various attempts have been made to determine what proportion of professional fee increases is due to the rising cost of medical malpractice insurance. If physicians respond only by raising fees, a doubling of liability premiums should produce a professional fee increase equal to the premium amount as a percentage of gross income. An AMA study attempted to estimate the impact of professional liability insurance rates on the cost of physicians' services.³⁴ Based on survey data, regression analysis was used to distinguish the effect of liability insurance premiums from all of the other factors affecting fees.³⁵ Table 6 presents a sample of professional procedure fees and the corresponding estimated effect on fees by professional liability.

TABLE 6

Procedure	Average Fee Including Liability Effect	Average Fee Excluding Liability Effect
Office visit/established patient	\$ 27.44	\$ 19.96
Electrocardiogram	33.62	26.72
Obstetric care/normal delivery	1,019.75	584.07
Hysterectomy	1,349.14	859.31

SOURCE: Reynolds, Rizzo & Gonzalez, *supra* note 34.

In recent years, the available evidence suggests that physicians have not been able to charge patients increased fees sufficient to offset fully their increased premium costs. As a result, increasing medical malpractice premiums have reduced physicians' net income from what it otherwise would have been, at least in some specialties and in some areas. Although comprehensive data comparing various rates of increasing medical malpractice premiums in different locales with the corresponding net incomes of physicians are not available, the following table provides an indirect measure of the extent to which malpractice premium increases have been absorbed rather than passed on to patients. Table 7 compares the index of the malpractice rates for the Florida Physicians Insurance Company (FPIC) for the period 1978 through May 1987 with the Consumer Price Index for urban consumers (CPI-U) and the medical care portion of

33. ACOG SURVEY, *supra* note 30, at 24. The most commonly reported fee increases were between 11% and 20%. *Id.* table 30.

34. Reynolds, Rizzo & Gonzalez, *The Cost of Medical Professional Liability*, 257 J. A.M.A. 2776 (1987).

35. *Id.* at 2779.

that index. The indices for physicians' fees and hospital costs are shown through 1985, the latest period for which they were available at the time of writing. Table 7 demonstrates clearly that malpractice insurance rates in Florida have increased much more rapidly than physicians' fees or other health care costs.

TABLE 7

**FPIC MALPRACTICE RATE INDEX AND CONSUMER PRICE INDICES:
1978-1987**

Year	FPIC Malpractice Rate Index	Consumer Price Index (CPI U)	Medical Care Price Index	Physicians Fee Index	Hospital Service Price Index
1978	100.0	100.0	100.0	100.0	100.0
1979	92.8	111.3	109.3	109.2	111.4
1980	81.2	126.3	121.2	120.7	126.0
1981	106.6	139.4	134.2	134.0	144.7
1982	126.6	148.0	149.8	146.6	167.5
1983	173.1	152.7	162.9	157.9	186.4
1984	217.1	159.2	173.0	168.9	201.8
1985	281.4	164.9	183.7	178.8	213.7
1986	523.7	168.1	197.6		
1987	785.4	173.3	209.2		

SOURCES: U.S. Government, Bureau of Labor Statistics (for indices and fee index). Malpractice rate index calculated from rates supplied by the Florida Department of Insurance.

Several explanations are advanced for the failure of physicians to shift the full cost of liability premium increases to consumers. Complete shifting of increased liability costs may be prevented by market competition among physicians.³⁶ Physicians' fees have been under severe pressure in recent years, especially in the urban areas. The sharp increase in the number of practicing physicians in Florida and the widespread development of preferred provider organizations

36. See Bovbjerg, *Medical Malpractice On Trial: Quality of Care is the Important Standard*, 49 LAW & CONTEMP. PROBS. 321, 323 (Spring 1986) (physician's ability to pass through full increase of liability premiums depends on insurance payment rules, market resistance to price rises, and how smoothly insurance market works).

(PPOs)³⁷ and health maintenance organizations (HMOs)³⁸ have brought intense competition to the health care market, which has generated pressure to hold down fees. Additionally, reimbursement restrictions imposed by Medicare, Medicaid, and other third-party payors³⁹ often limit physician fee increases.⁴⁰ These organizations have become more vigilant in controlling medical costs by developing extensive computerized systems to screen doctors' fees, by seeking reductions in fees where appropriate, and by refusing to compensate fully those fees believed to be excessive.

The apparent inability of Florida physicians to be reimbursed by their patients for increased costs of liability insurance and the resulting relative reduction in physicians' income also is consistent with the findings of other investigators. Another study found that the premium "pass-through" by physicians was about 75% effective; therefore, when liability premiums increased (and all other factors remained constant), physicians' net incomes fell.⁴¹ In addition, less visible costs of the medical malpractice system may affect physicians' incomes. Examples of such hidden costs would include such things as loss of physician work days (e.g., for depositions and trials),⁴² costly adaptations of practice style (e.g., seeing fewer patients or hiring additional office help), and decisions to obtain additional continuing medical education. Such factors are not quantified as easily as the direct cost of liability premiums, but, nevertheless, represent real financial expenses. While the physician may shift most of the increase in gross premium to the patient, some of these additional costs may

37. Preferred provider organizations (PPOs) are contractual arrangements between health care providers and groups of individuals insured under health insurance coverages that limit the amount of fees that can be charged to the insureds. By utilizing the group approach to fee negotiation, the PPO has more bargaining power with health care providers than would a single consumer. AMERICAN MEDICAL ASS'N, COUNCIL ON LONG RANGE PLANNING & DEV., *THE ENVIRONMENT OF MEDICINE* 68, 88-89 (1985).

38. Health maintenance organizations (HMOs) provide medical consumers with all, or almost all, of their medical care for a period of time in exchange for a fixed prospective payment. Providing consumers' health care needs at a fixed price increases the incentives for health care providers to reduce total health care fees. *Id.* at 68.

39. Medicare now reimburses hospitals for hospital admissions based on diagnosis-related groups (DRGs). DRG reimbursement involves paying the hospital a predetermined fee for a hospitalization involving a particular diagnosis. As with HMOs, the prospective nature of the reimbursement creates incentives for the hospital to hold down costs. *Id.* at 70-71.

40. FMA, *MALPRACTICE GUIDEBOOK*, *supra* note 29, at 41-43.

41. Zuckerman, Koller & Bovbjerg, *Information on Malpractice: A Review of Empirical Research on Major Policy Issues*, 49 LAW & CONTEMP. PROBS. 85, 107 (Spring 1986) (citing Sloan, *Economic Issues in Medical Malpractice*, in FMA, *MALPRACTICE GUIDEBOOK*, *supra* note 29, at 41-43).

42. Zuckerman, Koller & Bovbjerg, *supra* note 41, at 107.

need to be absorbed by the physician, resulting in an overall diminution of net income."

Florida medical malpractice insurance rates have increased substantially more rapidly than physicians' income or other medical costs during the past decade. The pace of premium increases has been especially great during the past four years. The effect of such increases on physicians has varied considerably; the rate increases were higher for high-risk physicians, such as neurosurgeons and obstetricians, and physicians in metropolitan Dade and Broward Counties sustained substantially greater increases than the rest of the state. Some physicians practicing in high-risk specialties now pay about one-fourth of their gross income for malpractice insurance, which suggests that malpractice insurance is approaching unaffordability, if it has not already reached it. Finally, the present analysis shows that medical cost constraints imposed by the government, employers, and insurers make it increasingly difficult for doctors to pass along the full costs of malpractice insurance premium increases to their patients.

III. POTENTIAL CAUSES OF INCREASED COSTS FOR MEDICAL MALPRACTICE LIABILITY INSURANCE

The assertion that the costs of medical malpractice liability insurance have increased dramatically during the past four years is uncontested. Far less certain and far more controversial are the reasons for this increase. Insurers and physicians frequently point to higher payments and more claims, while lawyers charge insurers with profiteering. If dramatically increased medical malpractice premiums pose a compelling societal problem, then understanding the causes of increased premiums should precede enactment of any legislative measures to remedy the problem. This part attempts to provide such an understanding by analyzing separately four factors frequently alleged to be causes of increased medical malpractice premiums: (1) increased loss payments; (2) excessive insurance company profits; (3) the insurance industry underwriting cycle; and (4) the risk classification system used to group physicians for rating and pricing purposes.

A. An Overview of Trends in Loss Payments

The primary role of an insurer is to spread risk. In return for the premiums paid by insureds, the insurer assumes the risk of financial losses of designated types from a large number of insureds. One primary source of insurer revenues, therefore, is policyholder premiums. The other main revenue source is investment income. Between

43. See Bovbjerg, *supra* note 36, at 323 (providers may or may not be able to pass through full increase when liability premiums increase).

the time premiums are collected and the time when losses attributable to the same policy year are paid, insurers invest the premium dollars. On the expense side, the largest share of expenditures is for loss payments to claimants to whom the insured party may be liable. Almost two-thirds of total insurance company expenses are represented by payments to such patient/claimants and their legal counsel.⁴⁴ Other, less important insurance expenses are internal operating costs and expenses for the insurance company's and the physician's legal counsel.

Because claims payments represent the largest share of insurance company expenses, a substantial increase in total medical malpractice claims payments (assuming a constant number of insured physicians) generally would suggest the need for price increases to a prudent and rational insurer. The need for increases in premiums charged physicians sometimes is delayed or even ameliorated by higher returns on the premium dollars invested by the insurer. Sooner or later, however, substantial long-term growth in paid claims likely catches up with and surpasses the growth in investment income, and the insurer must increase premiums if profitability is to be retained or restored.

This section explores total loss payments in the state of Florida during the past twelve years to determine what changes have taken place in this most important cost of doing business for insurance carriers. The data relied on were generated from a unique closed claim database maintained by the Florida Department of Insurance, consisting of all files closed by medical malpractice insurers in the state of Florida from 1975 through 1986. In the mid-1970s, Florida enacted legislation⁴⁵ in response to a previous wave of the medical malpractice crisis.⁴⁶ This legislation included a provision requiring insurance carriers to report the closing of any medical malpractice claim file whether or not the claim resulted in payment by the insurer.⁴⁷ As a result, more than 21,000 claims were reported to the

44. Payments to patients/claimants and their counsel represented 64.6% of the incurred costs of medical malpractice insurers for the policy year 1985, according to the Insurance Services Office, Inc., a non profit organization offering rating and other statistical services to insurance carriers. Insurance Servs. Office, Inc., Calendar Year 1987 Expense Provisions - Medical Professional Liability (Technical Services TS-PR-86-9) (Dec. 1, 1986) (copy on file at Georgetown Law Journal). Legal defense costs constituted 18.4% of insurance costs, and 17.0% were insurance company expenses. *Id.*

45. 1974 Fla. Laws, ch. 74-219.

46. See *Malpractice Crisis: How It's Hurting Medical Care*, U.S. News & World Rep., May 26, 1975, at 32 (rising rates of medical malpractice insurance and increasing number of suits and size of claims causing decline in quality of medical care).

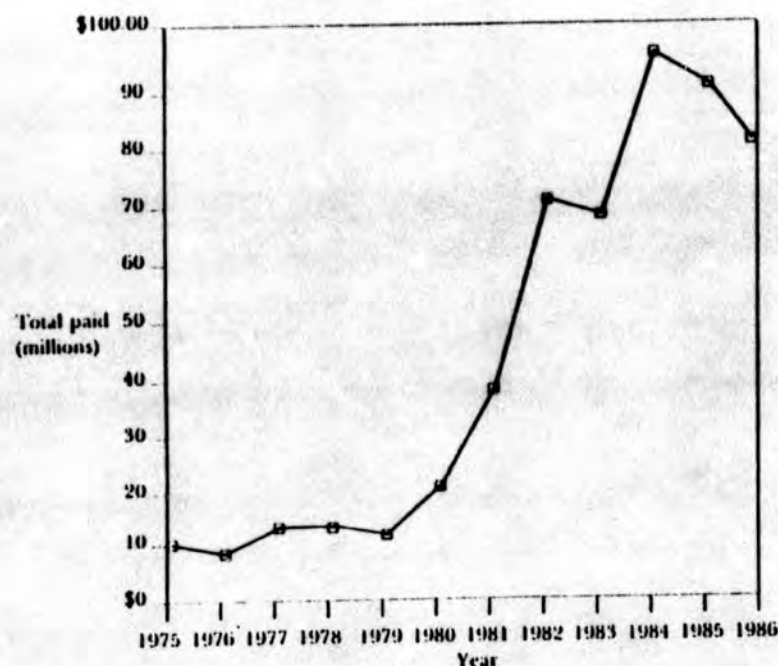
47. FLA. STAT. ANN. § 627.912 (West 1984). A physician's insurer may open a claim file in response to a number of events, including the filing of a lawsuit by an injured patient, notification from the physician that an incident has occurred that may lead to a claim, an oral or written claim for damages by a patient or a member of his family, or

Florida Department of Insurance from 1975 through 1986. The insurer was required to report more than forty separate pieces of information for each claim. This database constitutes a comprehensive compilation of information about closed claims extending over a sufficient period of time to establish meaningful trends.

The closed claims data show that approximately \$513 million was paid out by insurance carriers from 1975 through 1986 on malpractice claims against physicians in Florida. This amount includes not

FIGURE 1

TOTAL MEDICAL MALPRACTICE PAID CLAIMS IN FLORIDA
ALL SPECIALTIES: 1975-1986



SOURCE: Florida Department of Insurance medical malpractice closed claims data set. only payments actually received by claimants, but also legal fees for defense counsel and other litigation expenses. The annual amount of total paid claims in Florida was essentially unchanged from 1975 to 1979, but the total amount of paid claims increased dramatically from 1979 to 1984, as shown in figure 1. The total amount of paid claims

notice from an attorney that she is representing a patient. GAO, CLAIMS CLOSED IN 1984, *supra* note 23, at 12.

has decreased somewhat from its 1984 level, suggesting that the peak for claims payments probably occurred in 1984.⁴⁸ From 1975 through 1986, the number of total paid claims for Florida has grown at an average compound annual rate of slightly more than 20%. Since 1979, this rate of increase has been almost 30%.

Insurers set premiums with a view toward covering the losses they expect to pay arising from the policy year in question. Obviously, past loss experience may be indicative of future loss trends. Over time, therefore, trends in premiums should reflect changes in paid losses. This correlation is illustrated by figure 2, which compares an index of the average paid claim per Florida physician since 1978 with an index of medical malpractice premium rates.⁴⁹

It reveals that from 1978 through 1984, the rate of increase in claims payments per physician outpaced the rate of premium increases. As discussed below, that insurers were able to keep premium rate increases lower than the trend in loss payments during this period may suggest that they had invested the premium dollars they had collected at the unusually attractive investment rates then available. By 1984, however, the gap between the paid claims index and the premium index became so large as to make substantial price increases necessary if the balance between claims payments and premiums was to be restored. The apparent lack of any short term correlation between the dramatic increases in paid claims and relatively stable malpractice premiums until 1984 disappeared with the dramatic rise in premiums between 1984 and 1986. This rise establishes the long-term relationship between the increases in paid claims and premiums.

Because increased loss payments are the principal cause of increased malpractice insurance costs, the characteristics of loss payments and trends in these loss payments from 1975 through 1986 are analyzed in greater detail in part IV. For now it should be noted that increased numbers of claims (frequency)⁵⁰ and increased amount per claim (severity)⁵¹ have both contributed to the substantial increase in

48. This is not to imply that loss payments will continue downward. Population growth will cause the total amount paid for medical liability to increase, as will increases in the costs of settling claims. In the absence of any changes in the insurance and tort systems, loss payments can be expected to resume their upward trend.

49. The index of rates is based on rates charged by the Florida Physicians Insurance Company (FPIC) because a rate history for the FPIC was available after 1978; the rate history for the other major Florida medical malpractice carriers only dates from 1983. The rate index is based upon the FPIC's mix of insured risks, which does not necessarily mirror the composition of Florida physicians as a whole. Despite this possible limitation, the figure serves to illustrate the long term relation between premiums and claims payments.

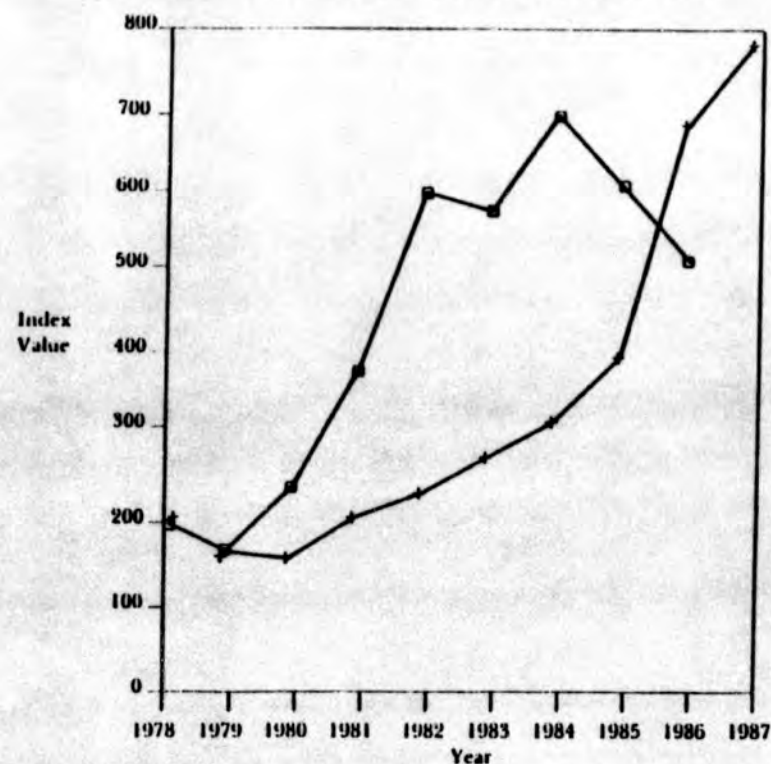
50. See *infra* part IV, A.

51. See *infra* part IV, B.

total paid claims, with increased severity exerting greater influence on the growth of loss payments.

FIGURE 2

INDICES OF MEDICAL MALPRACTICE PAID CLAIMS PER PHYSICIAN IN FLORIDA AND FLORIDA PHYSICIANS INSURANCE: 1978-1987



□ Paid Claims Index
+ FPI Rate Index

SOURCE: Calculated from data supplied by the Florida Department of Insurance.

B. Insurance Company Profitability

The charge that excessive insurance company profits are the source of high malpractice premiums is frequently voiced during debates on the medical malpractice crisis. In response, the insurance industry claims that it is experiencing a financial hemorrhage of the severest magnitude. Based upon the data analyzed by the authors, excessive profitability is not a cause of the medical malpractice problem. When total return on equity is used as a measure of profitability,

however, the insurance industry's financial position is less precarious than it claims.

I. Measure of Profitability: Return on Equity

The profitability measure used in this study is total return on equity. The rationale for using total return on equity rather than one of its components as a measure of profitability is rooted in the insurer's primary activity and responsibility, which is the taking of risk by providing insurance to society. To provide insurance, an insurer must have available sufficient surplus (capital) to absorb fluctuations in its financial results and to finance growth. Unexpected increases in the number of claims or the amount paid to settle each claim could result in premiums being insufficient to cover the cost of claims. When this occurs, the company's surplus is used to finance the loss until the relationship between premiums and claims can be restored.

The two major types of insuring organizations are mutual insurance companies and stock companies.⁵² Both types of companies co-exist and usually compete in the same markets. The primary difference between the two is in the ownership of the firms. Mutual companies are owned by their policyholders; these organizations are (or should be) managed for the policyholders' benefit. Stock companies, on the other hand, are owned by shareholders; these companies must be managed with the (possibly competing) interests of both policyholders and shareholders in mind.⁵³

In the case of a shareholder-owned insurance company, the return on equity must be competitive with returns that could be earned in other sectors of the economy with equivalent risk. If the return is too low, capital will leave the insurance business, which in turn will restrict the supply of insurance.⁵⁴ The decreased availability of insurance will cause prices to rise until profitability has been restored, at which point price and supply stability will return. In the United States, capital flows can take place relatively unimpeded. Few, if any, restrictions are placed upon a firm's management when it wishes to increase the firm's capital. While withdrawing capital or withdrawing from insurance markets (which has essentially the same effect as far as supply is concerned) is more difficult, it can and does take place when

52. See generally G. REJDA, *PRINCIPLES OF INSURANCE* 517-19 (2d ed. 1986).

53. The relationship between the supply of insurance and insurance company surplus is established through the premiums' written to surplus ratio. The National Association of Insurance Commissioners uses a guideline figure of three to one. NATIONAL ASS'N OF INS. COMM'RS, USING THE NAIC INSURANCE REGULATORY INFORMATION SYSTEM 6 (Property Liability ed. 1987). In other words, it is recommended that state regulatory authorities allow insurers to write no more than three dollars of premium for every one dollar of surplus. If surplus is reduced for any reason, such as underwriting losses, investment losses, or withdrawal of capital from the firm, the ability to write insurance potentially is reduced.

the firm's management has no expectation of return by remaining in the market.

Mutual companies also must earn an excess of premium over costs. Although such firms are classified as non-profit, the economic principles of the insurance business have the same validity for mutual companies as they do for stock companies. Like a shareholder-owned firm, a mutual company must have surplus to absorb fluctuations in underwriting profitability; therefore, it must also attract and retain capital. A mutual company also must generate surplus to finance the growth of the firm. If the market perceives that the firm is in danger of insolvency, the firm's insureds can (and will) simply cancel or not renew their policies and shift their business to a more stable competitor — whether it is a stock, mutual, or some other form of organization.

The measure of profitability considered here — total return on equity — consists of four parts: (1) underwriting result; (2) net investment income; (3) realized capital gains; and (4) unrealized capital gains. Figure 3 outlines these components of total return on equity. Underwriting result refers to the profitability of the firm's insurance portfolio. The remaining portions of return to the insurance carrier occur because insurance premiums are received by the firm before losses are paid, enabling the company to invest the premiums in the interim. Net investment income is comprised of the amount of cash income (mostly dividends and interest) received by the insurer, less investment expenses incurred to manage these monies. Realized gains arise when the firm sells an asset (such as stock or bond) for more than its cost. Unrealized gains occur when the price of an asset goes up after its purchase by the company but the security has not yet been sold.

The approach presented here to measuring the profitability of insurers involves potentially controversial choices about how to handle policyholder dividends and unrealized capital gains. On one hand, this analysis treats policyholder dividends as expense items that are deducted from revenue to arrive at taxable income.⁵⁴ These dividends operate functionally as price reductions for policyholders, not

54. Some consumer organizations argue that policyholder dividends should be included as profits, not expenses, because they represent a return on capital. See NATIONAL ASS'N OF ATTORNEYS GEN., AN ANALYSIS OF THE CAUSES OF THE CURRENT CRISIS OF UNAVAILABILITY AND UNAFFORDABILITY OF LIABILITY INSURANCE 14 (May 1986); UNITED STATES GEN. ACCOUNTING OFFICE, INSURANCE: PROFITABILITY OF MEDICAL MALPRACTICE AND GENERAL LIABILITY LINES 5 (July 1987). The rationale for such a position is that policyholder dividends are discretionary price concessions within the control of company management. Because firms could decide not to use dividends to reduce prices, such amounts are available to company owners if they so choose and therefore should be

FIGURE 3

COMPONENTS OF INSURER TOTAL RETURN

Underwriting gain (loss)	XX
Net investment income	XX
Taxes	-XX
After tax operating result	XX
Realized gains	XX
Unrealized gains	XX
Total dollar return	XX

as dividends that investors typically earn on stock investments. On the other hand, unrealized capital gains are included as part of the profit of the firm in this study. This approach is contrary to the position of the insurance industry, which believes unrealized capital gains should be excluded.⁵⁵

Unrealized gains should be included in return on equity for two reasons. First, management can convert the unrealized gains into cash at any time by selling the securities, thereby removing the uncertainty associated with them. Second, traditionally accepted investment theory includes unrealized gains in the rate of return calculation because the total return on equity available to investors, including unrealized capital gains on premium dollars, determines whether investment capital is attracted to the industry.⁵⁶

included in income. The insurance industry argues, on the other hand, that the price reductions are usual, customary, and expected by the marketplace. Thus, they are not discretionary and must be made available to its customers. The Internal Revenue Service recognizes policyholder dividends as a proper deduction from revenue in arriving at taxable income. In the opinion of the authors, this places policyholder dividends in the category of expense items that are deducted from revenue to arrive at (before tax) income available to firm owners. In other words, policyholder dividends are a legitimate business expense rather than part of the net income of the firm.

55. The basis of the industry's argument is that unrealized gains are uncertain, they may not be available when the securities are sold in the future. See INSURANCE SERV. OFFICE, INC., 1986 INSURER FINANCIAL RESULTS: AN ANALYSIS OF THE STRENGTH OF THE PROPERTY CASUALTY INSURANCE INDUSTRY'S RECOVERY 15 (1986).

56. According to investment theory, an investment return consists of both interest or dividend income and price appreciation or depreciation. Price appreciation consists of both realized and unrealized gains. These two components of profit constitute the total return from undertaking an investment, and this return must be competitive in the marketplace for capital to be attracted and retained. In an insurance context, the insurer commits its surplus at the beginning of the year to support a group of insurance risks, i.e., it makes an investment in insurance each and every year that it decides to remain in the business of underwriting risks. In exchange, it receives a reward consisting of both investment income and price appreciation. To exclude the latter is to

2. Profitability of Property-Casualty Industry: 1977-1985

An analysis of insurance industry profits found no evidence to support the claim of excessive long-term profits. Total return on equity for the property-casualty insurance industry measured over an entire underwriting cycle has been slightly less than the average return for American industry as a whole. Largely because of the underwriting cycle and variations in investment rates of returns, the profitability of the insurance industry often varies dramatically from one year to another.⁵⁷

Table 8 shows that from 1977 through 1985, the average annual compound rate of return for the property-casualty industry was 15.9% on a "statutory" return on equity basis. Table 8 divides the return on equity figure into its four component parts so that the contribution of each part to the total can be ascertained. In addition, figures are presented for each year since the start of the last underwriting cycle in 1977.

The "statutory" return on equity figure is prepared according to accounting procedures, prescribed by regulatory authorities, that are designed to gauge the solvency of insurance carriers as opposed to precisely measuring profitability.⁵⁸ At the request of the authors—in their role as research scholars for Florida's Academic Task Force for Review of the Insurance and Tort Systems and armed with subpoena power—more than a dozen major insurance carriers voluntarily provided return on equity figures⁵⁹ on both a statutory basis and on the

understate the actual return earned for accepting insurance risks. See generally R. RADCLIFFE, *INVESTMENT CONCEPTS, ANALYSIS AND STRATEGY* 9-10 (2d ed. 1987).

57. See *infra* notes 70-76 and accompanying text (describing effect of interest rates on underwriting cycle and insurance company nonprofitability).

58. "Statutory" total returns are found using data prepared according to statutory accounting principles as prescribed by the National Association of Insurance Commissioners. T. TROTT & C. BRISTIN, *PROPERTY LIABILITY INSURANCE ACCOUNTING AND FINANCE*, INC. 2-15 (2d ed. 1983).

59. The authors, as members of the research staff for the Academic Task Force for Review of the Insurance and Tort Systems, sent extensive questionnaires to 41 major property casualty insurance carriers doing business in the State of Florida. Each insurer was provided both with a 160 page printed copy and a computer disk containing a Lotus 1-2-3 spreadsheet that had been programmed with the questions propounded to the insurers as well as with blank cells for responding to the questions. The questionnaires asked for a wide variety of information about profits, loss payments, insurance operations, and other aspects of the insurance business.

The statute creating the Academic Task Force for Review of the Insurance and Tort Systems granted the Task Force subpoena power. Tort Reform and Insurance Act of 1986, ch. 86-160, § 63(6), 1986 Fla. Laws 695, 758. Without exercising this subpoena power, the Academic Task Force received comprehensive returns from all insurers except those who were excused from providing the information because they had

"generally accepted accounting principles" (GAAP) basis more commonly used outside the insurance industry.⁶⁰ In most instances, GAAP

TABLE 8

PROPERTY-LIABILITY INSURANCE STATUTORY RETURN ON EQUITY: 1977-1985

Consolidated Total— Property Liability	1985	1984	1983	1982	1981	1980	1979	1978	1977
Underwriting	-36.3%	-29.3%	18.2%	-15.4%	-8.7%	-4.0%	0.1%	8.7%	7.8%
Net investment income	30.6	27.0	26.2	27.6	25.9	26.1	26.2	24.8	23.6
Policyholder dividends	-3.4	-3.2	-3.7	-3.7	-3.6	-3.8	-3.7	-4.3	-3.3
Taxes	3.1	2.5	2.0	1.3	-0.1	-1.4	-2.5	-4.7	-4.1
After tax operating result	-6.0	-3.0	6.3	9.8	13.5	16.8	20.0	24.5	24.0
Realized gains	8.6	4.7	3.5	1.1	0.5	1.3	0.8	0.2	1.3
Unrealized gains	8.2	-4.4	2.2	5.4	-5.2	10.1	5.7	1.4	-4.4
Total	10.8%	-2.6%	12.0%	16.2%	8.9%	28.1%	26.6%	26.1%	20.9%
Annual average	15.9%								

SOURCE: Calculated from data provided in A.M. BEST CO., *AGGREGATES & AVERAGES: PROPERTY CASUALTY* (1978-1986 eds.).

figures for return on equity were two or three percentage points less than statutory figures. For example, a 15% statutory return on equity figure represents the same profitability as a 12% or 13% GAAP return on equity figure. This suggests that on a GAAP basis, the return on equity during the period 1977 through 1985 was between 13% and 14%.

A comparison between the profitability of the property-casualty

withdrawn from the Florida market, recently had undergone a major corporate reorganization, or were small carriers that had not used data processing until recently and therefore had not compiled the information requested. Once received, the results of the insurance company survey were loaded from personal computer terminals into the mainframe at the University of Florida and were analyzed using both SAS (Statistical Applications System) and Lotus 1-2-3.

60. Generally Accepted Accounting Principles (GAAP) are a set of rules and procedures promulgated to provide a relatively uniform measurement of income, as opposed to Statutory Accounting Procedures (SAP), which emphasize the solvency of the insurance company. The GAAP rules are developed and published by the Financial Accounting Standards Board, an accounting profession organization. A more detailed explanation of the difference between the GAAP and the SAP rules can be found in T. TROTT & C. BRISTIN, *supra* note 58, at 15-25.

insurance business and the rest of American industry has been completed by the Insurance Services Office, Inc.,⁶¹ which treated policyholder dividends and unrealized capital gains in the manner described above.⁶² This analysis, shown in table 9, asserts that the profitability of the property-casualty industry is slightly less than that of Standard & Poor's 500 Stocks and of Standard & Poor's Financial Corporations.

TABLE 9

SIMPLIFIED GAAP ADJUSTMENT RETURN ON NET WORTH FOR UNITED STATES PROPERTY-LIABILITY INSURANCE INDUSTRY COMPARED TO UNITED STATES INDUSTRY: 1977-1985

Year	S&P Financial	S&P 500 Stocks	Property-Liability Insurance
1977	14.1%	33.5%	16.8%
1978	15.6%	14.1%	18.8%
1979	15.7%	15.4%	18.4%
1980	13.8%	14.1%	17.5%
1981	12.7%	13.8%	8.1%
1982	11.4%	30.7%	11.1%
1983	11.6%	11.0%	8.9%
1984	9.1%	13.2%	-1.0%
1985	9.2%	10.7%	8.1%
Average	12.6%	12.9%	11.7%

SOURCE: INSURANCE SERVICES OFFICE, INC., *supra* note 62, at 51.

NOTE: End of year net worth was used in the calculations. Unrealized capital gains were reduced by 28% to account for federal income taxes.

3. Medical Malpractice Profits: 1977-1985

Table 10 displays "statutory" total return on equity for two groups

61. Insurance Services Office, Inc., is a non-profit corporation that provides a variety of statistical and other services to over 1300 property-liability insurers throughout the United States. Its services are advisory only, and member companies are free to adopt different prices or policy language.

62. INSURANCE SERVICES OFFICE, INC., *INSURER PROFITABILITY: A LONG-TERM PERSPECTIVE* 51 (Apr. 1987).

of property-liability insurers—those who only write medical malpractice insurance and those whose major line of business is medical malpractice insurance.⁶³ The average annual compound rate of return on equity for these insurers from 1977 through 1985 was 16.3%. This return was slightly greater than the return in the property-casualty industry as a whole, but it still was well within the normal range for American corporations.

TABLE 10

STATUTORY RETURN ON EQUITY FOR MEDICAL MALPRACTICE PREDOMINATING PROPERTY-LIABILITY INSURERS: 1977-1985

	1985	1984	1983	1982	1981	1980	1979	1978	1977
Underwriting	-69.4%	-55.7%	-47.3%	-39.3%	-35.4%	-23.5%	-16.6%	-6.7%	-13.2%
Net investment income	67.6	65.2	55.8	62.9	57.1	48.9	44.3	37.7	39.1
Policyholder dividends	-3.5	-4.0	-2.4	-3.1	-2.7	-1.8	-1.2	-4.5	-1.7
Taxes	0.5	0.9	-4.0	-0.4	-1.6	-5.2	-4.3	-6.1	-7.7
After tax operating result	-4.7	6.4	2.1	20.0	17.4	18.4	21.7	20.5	16.5
Realized gains	12.3	0.9	5.2	2.3	0.3	0.8	0.4	-2.4	0.3
Unrealized gains	4.3	-0.8	-0.1	0.4	1.6	2.8	0.6	-0.3	0.2
Total	11.9%	6.4%	7.2%	22.7%	19.3%	22.1%	22.7%	17.8%	16.9%

SOURCE: Calculated from data reported by A.M. Best Co., *AGGREGATES & AVERAGES: PROPERTY-CASUALTY* (1978-1986 eds.).

NOTE: Return on equity calculated using beginning of year surplus.

The data in table 10 also illustrate several significant points. First, at the national level, insurers have consistently lost money on underwriting their insurance operations since 1977. Moreover, the underwriting loss has deteriorated steadily to the point where it produced a 69.4% loss on surplus in 1985 (the latest year for which data are available).⁶⁴ Second, investment income as a percent of equity has increased steadily and, except for 1985, has more than offset the underwriting loss in spite of declining interest rates since mid-1981.

63. The insurers included are those classified as "Medical Malpractice Predominating" by A.M. Best Co., a data gathering, analysis, and rating organization that specializes in insurance companies. Best is neither owned nor controlled by the insurance industry. A Best official defined "predominating" to mean a company whose medical malpractice insurance premium volume was at least 60% to 70% of its business. Telephone conversation with Allison Cooley, A.M. Best Co. (Mar. 10, 1988).

64. The term "loss on surplus" is defined as the amount of dollar loss divided by the surplus or capital invested in the business.

Third, the industry paid income taxes from 1977 through 1983 — thus indicating profitability — but in 1984 and 1985 its underwriting losses were of sufficient magnitude to generate a recapture of income taxes paid in prior years. Finally, the industry's after tax operating profit showed a marked and sudden deterioration in 1983 when compared to the six previous years. This trend persisted in 1984, and in 1985 operating results produced a negative return on equity.

The return on equity measure of profitability cannot be used by itself to evaluate an insurance company's financial performance in a given line, such as medical malpractice, or in a given state, such as Florida, because companies do not allocate expenses and surplus by line or by state. Nonetheless, two measures of profitability for medical malpractice insurance in the state of Florida are available. First, the two insurers that currently are the second and third largest medical malpractice providers in the state of Florida operate only in Florida and profitability figures for these carriers are available. Second, the underwriting results — both premiums and expenses — for the Florida operations of other malpractice insurers can be analyzed and compared with nationwide underwriting results.

The return on equity figures for the two exclusively Florida medical malpractice insurers are atypical.⁶⁵ One insurer, the Florida Physicians Insurance Company, is emerging from a period of extreme financial distress; consequently, its figures are not indicative of long-term profitability. The return on equity figures for the other carrier, Physicians Protective Trust Fund, were extremely volatile — usually high — in the earlier years because it began operations in 1975 without any paid-in capital or contributed surplus. The equity against which profitability is measured, therefore, was extremely low.⁶⁶

A comparison of medical malpractice underwriting results only — i.e., excluding consideration of the role of investment income in profitability — between Florida insurers and national averages shows no clear persistent differences, although offsetting variations may exist on a year-to-year basis.⁶⁷ Underwriting profitability is expressed in a

65. The annual return on equity figures for these two Florida insurers are compiled in table A.

66. The Physicians Protective Trust Fund's recent results are probably more representative of expected profitability, but they overstate it because the insurer's leverage ratio (i.e., premiums to surplus) is over twice as large as that of the typical insurer. This causes the return on equity figure to be higher than it would be if a lower ratio were present.

67. Generally, the approach used in the previous section cannot be used in isolation to measure a company's financial performance in a given state, because companies do not allocate their surplus on a state-by-state basis. Consequently, it is necessary to

calculation called the "combined loss and expense ratio," which, simply stated, is equal to losses and expenses divided by premiums. A higher ratio, therefore, means lower underwriting profitability. The average adjusted loss ratio (which ignores expenses) for Florida from 1976 through 1986 was 81.5 compared to a nationwide ratio of 87.5, thus indicating slightly greater profitability for medical malpractice insurers in Florida than the nationwide average. In other words, although physicians face higher malpractice premiums in Florida than elsewhere, the position of medical malpractice insurers in Florida is neither substantially better nor worse than that of carriers in other jurisdictions.

examine the multiline and/or multistate company's loss ratio. Multiline refers to a company that underwrites more than one line of insurance, e.g., medical malpractice and automobile insurance. Multistate refers to firms that sell insurance in two or more states.

Table B contains the adjusted loss ratio for medical malpractice insurers for Florida and the same ratio for St. Paul's medical malpractice experience in Florida. St. Paul Fire and Marine Insurance Company, the largest medical malpractice insurer in Florida, is a multiline, multistate firm. The adjusted loss ratio is equal to losses incurred divided by premiums earned after policyholders dividends. These terms are technical terms commonly used in the insurance industry. "Losses incurred" is defined as loss payments actually made during a period plus estimates of amounts that will be paid in the future. "Premiums earned" is a measure of the company's revenue or income for the time period.

Adjusted loss ratio is an incomplete measure of profitability because it does not take account of the company's expenses, nor does it include investment income or realized and unrealized gains. The data reported in table B cover the period from 1975 (the first year that medical malpractice was reported as a separate line) to 1986. All companies writing medical malpractice insurance in Florida are included except Florida Physicians Insurance Company, the trust funds (of which Physicians Protective Trust Fund is the largest), the Patients Compensation Fund, and the Florida Medical Malpractice Joint Underwriting Association.

The data for the past three years demonstrate the poor underwriting results both in Florida and across the country. Loss adjustment expenses and underwriting expenses must be added to measure underwriting profitability and these two items add about another 45% to the figures shown in table B. Thus, if the combined loss and expense ratio came to 130%, a loss of 30 cents is occurring for every dollar of table B premium. As noted above, however, investment results need to be included to accurately assess profitability. Even when this is done, the financial results from recent years show no excess profits, and the long term average is very close to overall profitability for the property liability industry.

TABLE A

STATUTORY RETURN ON SURPLUS FOR TWO MAJOR FLORIDA MEDICAL MALPRACTICE INSURERS

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
Florida Physicians Insurance Company											
Underwriting	N/A	20.1%	47.6%	-98.7%	-47.1%	-91.0%	-149.1%	-12.3%	-188.8%	-164.1%	-101.1%
Interest, dividends, etc.	N/A	16.5	31.7	47.4	58.7	82.9	106.1	33.6	67.8	120.8	61.1
Realized capital gains	N/A	-0.3	0.0	0.2	-0.5	6.6	-19.2	-4.0	-71.3	-13.0	60.7
Unrealized capital gains	N/A	0.2	-0.2	-7.0	-2.8	-22.8	25.2	7.5	33.0	-21.2	-4.6
Total return*	N/A	36.5%	79.1%	-58.1%	8.3%	-24.1%	-35.0%	24.8%	-137.3%	-61.4%	-17.8%
Physicians Protective Trust Fund*											
Underwriting	-78.2%	-166.2%	-55.2%	-61.4%	-416.1%	-1033.4%	-89.4%	-162.6%	-36.7%	-49.4%	-86.4%
Interest, dividends, etc.	128.5	222.2	114.9	106.2	508.6	1104.5	94.4	160.6	88.0	36.1	45.1
Realized capital gains	0.0	14.6	0.0	1.3	-9.5	3.1	2.1	13.2	1.7	8.0	8.8
Unrealized capital gains	49.7	-54.6	-16.0	-28.0	-240.4	-180.0	-80.9	-68.8	-21.0	33.6	13.8
Total return	100.0%	16.2%	41.7%	18.1%	-157.4%	-105.8%	88.0%	-57.6%	34.0%	48.4%	31.3%

Source: Insurance company questionnaire responses

Notes:

* Return is after policyholders' dividends and after income tax. Note, however, that no federal income tax was levied against unrealized capital gains. Such a tax liability may be incurred if and when the gains are realized. The amount of the tax liability is unknown and will depend upon the extent to which the realized gain in securities prices is offset by underwriting losses. End of year surplus was selected by the company in calculating the return on surplus.

* Physicians Protective Trust Fund, in reporting this data, included a cautionary letter concerning the use of total return on surplus figures for a trust fund. A copy of the letter is on file at the *Georgetown Law Journal*.

* See the above note concerning federal and state income taxes. Beginning of the year surplus was used by Physicians Protective Trust Fund in calculating the return on surplus.

TABLE B

ADJUSTED LOSS RATIO MEDICAL MALPRACTICE LIABILITY INSURANCE:
1975-1986

Year	Florida		Countrywide	
	All Companies	St. Paul	All Companies	St. Paul
1975	16.6	4.4	66.5	7.1
1976	94.5	12.6	48.5	13.5
1977	57.6	13.6	41.8	22.3
1978	26.3	37.9	60.6	36.4
1979	67.6	47.9	75.3	48.2
1980	83.6	94.0	82.6	56.2
1981	56.2	48.8	99.5	61.8
1982	89.8	64.5	111.4	67.7
1983	89.7	77.5	112.3	77.1
1984	93.4	73.8	110.9	80.2
1985	131.4	113.6	120.7	86.9
1986	106.7	92.6	99.1	79.8
Average 1976-1986	81.5	61.5	87.5	57.3

Source: A.M. Best Co., *ALSTATS & AVERAGES* (1978-1986 eds.)

Note: Adjusted loss ratio is equal to losses incurred divided by premiums earned less policyholder dividends. Since St. Paul Fire and Marine Insurance Company is a multilane, multistate firm, its return on equity figures reflect not only its Florida medical malpractice experience but also the company's medical malpractice experience from other states and other lines of insurance. Under these circumstances, the firm's underwriting results must be examined to gauge one part of the profitability of medical malpractice insurance. Underwriting results are available on a state-by-state basis whereas the return on equity figure is countrywide and reflects the experience of all lines of insurance.

4. The Role of Excess Profits in Escalating Premium Rates

From 1977 through 1985, a comparison of the total return on equity for liability insurers with those of other American corporations shows that profits for insurance companies were not excessive. Furthermore, examination of profitability of medical insurers demonstrated approximately the same rate of return as for liability carriers as a whole. The authors, therefore, reject the assertion that excess insurance company profits are a cause of the medical malpractice crisis. On the other hand, the liability insurance industry's financial condition is not nearly as serious as the industry sometimes claims when it focuses upon underwriting results or when it focuses only on the year 1985--the worst year in a nine-year cycle.

C. THE UNDERWRITING CYCLE

The phenomenon known as the "underwriting cycle" is unique to the insurance industry and represents a significant cause of the periodic malpractice insurance crises.⁶⁸ The length of the underwriting cycle is defined by the number of years in which insurer underwriting profits cycle from a high point to a low point and back again. Such cycles have always been a feature of the insurance industry, but the most recent cycle (1977 through 1986) was the longest in history and probably the most severe (i.e., the greatest difference between the high point and the low point).

While changes in demand typically influence economic cycles, insurance underwriting cycles reflect primarily changes in supply. A description of the underwriting cycle begins with a highly profitable insurance market that attracts capital and encourages the formation of new companies. The degree of competition increases as newly formed companies cut rates, forcing existing companies to do the same to protect their market share. Rate-cutting continues until the underwriting losses exceed the amount that insurers are willing to bear, at which point some insurers withdraw from the market, either voluntarily or because of insolvency. This shrinkage in supply permits the remaining insurers to raise rates to more profitable levels. The rate increases occur quickly, and usually are accompanied by more stringent underwriting standards, which result in more frequent refusals by insurers to provide insurance. Restored profitability, due to higher rates, attracts new capital and the cycle begins anew.

1. Effect of Interest Rates on the Underwriting Cycle

Underwriting cycles are frequently, but not always, driven by changes in interest rates. In addition, interest rates may prolong an underwriting cycle. The most recent cycle was probably influenced in both ways.

Insurance premiums represent one of the two main sources of revenue for insurance carriers; the other source is the profits earned by insurance carriers from investing premium dollars between the time premiums are received from the insured and the time these funds are disbursed to pay for losses and expenses attributable to that policy year.⁶⁹ During the late 1970s and early 1980s, investment rates

68. For a more complete description of the underwriting cycle, see Stewart, *Profit Cycle in Property-Liability Insurance*, in 2 ISSUES IN INSURANCE 79 (1981).

69. For an overview of insurance company operations, see G. REBOA, *supra* note 52, at 535-54.

of return were unusually high. Rates of return on Treasury bills reached an unprecedented level of almost 15.5% in 1981.⁷⁰

Under these circumstances, insurers aggressively reduced rates to insure as many risks as possible and thereby capture and invest premium dollars.⁷¹ As in previous underwriting cycles, rates were substantially reduced because carriers expected to offset any losses with investment income. This practice, called cash-flow underwriting, is not necessarily unsound or imprudent business practice. It represents a legitimate and desirable response from insurers that benefits insurance buyers in the form of reduced rates.

During the period 1979 through 1981, however, excesses of cash-flow underwriting occurred, and virtually all insurers were forced into unreasonable price reductions to preserve their market shares. The result, in many instances, was cutthroat price competition resembling an old-fashioned gasoline price war. Insurance company chief executives were faced with cries from the heads of their marketing operations that unless prices were reduced, market share would be lost. Such claims, in most instances, prevailed over the protests of actuaries that the premium rates being charged in 1981 were not actuarially sound. This intense price competition resulted in premium rates lower than those that ordinarily would have been charged in view of the industry's claims paid experience and actuarially sound projections of future losses. Premium rate increases lagged proportionately behind claims paid experience. As a result, the inevitable upward pressure on insurance rates as a result of increasing paid claims was delayed and obscured.

In other words, in hindsight, premium rates for physicians and others in 1981 were lower than they should have been. During the period 1978 through 1980 when prices, as measured by the Consumer Price Index, increased a total of 26.3%, medical malpractice premiums in Florida actually decreased 19%.⁷² The large price increases that occurred during the most recent years of 1984 through 1987 are all the more dramatic because they occurred against a base that was artificially low as a result of the underwriting cycle.

One question that legitimately may be asked is, if prices were too low in 1981, why did insurance companies not withdraw from the marketplace and then return only after prices increased to allow for

70. The United States Treasury bill rate in 1981 fluctuated between 11.471% and 15.548% with an average rate of 13.776%. ECONOMIC REPORT OF THE PRESIDENT, H.R. DOC. NO. 140, 98th Cong., 2d Sess. 298-99 (1984).

71. Jack Mosely, Chairman and Chief Executive Officer of USF&G Corporation, Testimony Before the Academic Task Force for Review of the Insurance and Tort Systems, vol. 1, at 129-33 (Miami, Fla., Feb. 3, 1987).

72. BUREAU OF LABOR STATISTICS, U.S. DEPT. OF LABOR, HANDBOOK OF LABOR STATISTICS table 110, at 356 (June 1985).

an acceptable level of profit? The answer appears to be their concern over the loss of market share and the difficulty of reentering the insurance market. Most insurance is not sold directly by insurance companies to physicians or other insureds, but instead is sold through agents or brokers. If a carrier withdraws its policies from an agent or broker during a period of inexpensive coverage and low profits, that carrier is less likely to be used by an agent or broker when prices and profits return to higher levels. The disruption to the agent or broker's business caused by such withdrawal may well lead the broker or agent to conclude that the carrier did not stand by her in tough times and should not now reap the benefits of profitable times.

The historically high interest rates of 1981 did not last; as interest rates declined, premium increases became necessary to offset the effect of reduced investment income. The past two years have revealed a return of interest rates to more normal levels and a corresponding increase in prices as insurers sought to restore overall profitability.

Exactly how did the insurance underwriting cycle correlate with premium rates charged Florida physicians? Columns (2) and (3) of table 11 correlate the insurance underwriting cycle with premium rates (columns (4)-(6)) charged Florida physicians. Column (2) shows the "combined ratio" for the insurance industry for the years 1978 to 1986, and column (3) reports the same ratio for the medical malpractice line.⁷³ The combined ratio relates incurred claims and expenses (other than investment expenses) to premiums. A combined ratio in excess of 100% indicates an underwriting loss while a ratio less than 100% indicates an underwriting profit.

Column (4) of table 11 contains medical malpractice rates for the Florida Physicians Insurance Company (FPIC) for the years 1978 to 1987. The trends in rates shown are for a family practice physician (no surgery) in the Miami area, but other specialties and other sections of the state show similar trends. Note that the FPIC's rate reduction in 1979 and 1980 correlates with the rising industry combined ratio. The FPIC's rates began rising in 1981, with the rate of increase accelerating sharply and correlating again with the falling

73. Ideally the medical malpractice combined ratio would be compared to malpractice liability rates. However, the malpractice combined ratio is only available through 1986, and an important year (1987) would be missing from the data series. Consequently, the industry combined ratio—the trend in the ratio which is important in tracking the relationship between the underwriting cycle and premium rates—was also used. The medical malpractice combined ratio is included in column (3) to illustrate that for the period for which figures are presented, the ratio is higher than the industry figure, but follows a similar trend.

industry combined ratio in 1985, 1986, and the first quarter of 1987. Column (5) of table 11 shows the St. Paul Fire and Marine Insurance Company's Miami rates for a family physician for the years 1982 through the middle of 1987. They follow essentially the same pattern as the FPIC's rates. The rates for the Physicians Protective Trust Fund (PPTF), shown in column (6) for the years 1983 to 1987, show a similar trend.

TABLE 11

THE PROPERTY-LIABILITY INSURANCE UNDERWRITING CYCLE AND FLORIDA
MALPRACTICE INSURANCE RATES: 1978-1987

Combined Year	Combined Ratio		FPIC Rates	St. Paul Rates	PPTF Rates
	Industry	Medical Malpractice			
1978	97.4	104.9	\$ 2,680		
1979	100.6	113.9	2,486		
1980	103.1	129.2	2,177		
1981	106.0	137.6	2,857		
1982	109.6	150.9	3,393	\$ 4,004	
1983	112.0	151.2	4,638	4,868	\$ 4,433
1984	118.0	162.2	5,819	6,414	5,704
1985	116.3	166.9	7,541	8,820	8,349
1986	108.0	139.5	14,034	10,115	12,107
1987	103.6*	N/A	21,049	20,425	14,663

*After dividends to policyholders. A.M. Best Co., AGGREGATES & AVERAGES 89, 91 (1987).

*First quarter only. A.M. Best Co., BEST'S REVIEW 91 (JULY 1987).

The sharp acceleration in rates that corresponds with the upturn in the underwriting cycle and tightened underwriting standards that accompany increased rates are major exacerbating causes of the crisis in medical malpractice insurance during the last three years. Clearly, however, the underwriting cycle and alleged poor insurance company management and investment practices⁷⁴ are not the primary cause of increases in the cost of malpractice insurance. Two reasons support this conclusion. First, medical malpractice premiums increased at a rate substantially greater than inflation even when the accelerations and decelerations of the rate of price increases that result from the underwriting cycle are smoothed out. During the period from 1978 through 1987, malpractice premiums increased at

74. See ASSOCIATION OF TRIAL LAWYERS OF AM., THE INSURANCE CRISIS: A STUDY IN DECEPTION 13 (1986) (concluding that insurance "crisis" was "orchestrated and directed" by property casualty insurance industry).

an average annual compound rate of 25.7%.⁷⁵ Although this figure is not as dramatic as the average annual increases of 67.1% since 1985, which results when the underwriting cycle concentrates price increases in a few years, it is still a substantial enough price increase in an area of critical public importance to generate concern among public decisionmakers.

Second, the underwriting cycle is not unique to medical malpractice insurance, nor even to third-party liability insurance in general. The underwriting cycle affects other types of insurance such as first-party fire, windstorm, and other property insurance. These lines have not experienced comparable premium increases, however, nor have most other liability lines.⁷⁶ To some extent, the effect of the underwriting cycle is greater on medical malpractice lines with a "long tail," that is, a substantial time lag between the receipt of policy premiums by the insurer and the disbursement of funds for claim payments and expenses. The "long tail" exacerbates the underwriting cycle by increasing the financial impact of differential rates of return on investments and inducing fiercer competition among malpractice insurers to attract premium dollars. Nonetheless, the effect of the "long tail" on the malpractice line is not sufficient to explain the difference between increases in medical malpractice premiums and those in first-party coverages not substantially affected by the legal system.

2. Can Underwriting Cycles Be Controlled?

The underwriting cycle and its adverse effects on the malpractice insurance market are probably not controllable. Theoretically, three possible sources of control for underwriting cycles exist: (1) the insurance industry, (2) the states, and (3) the federal government. Control by the industry is highly unlikely in the foreseeable future. Contrary to the frequent assertion that insurance carriers collude and conspire to maintain high profits, the artificially low prices of 1981 that contributed to the dramatic price increases and the tightening of the market in 1984 reflect excessively fierce competition. The industry is composed of over two thousand insurance companies, with approximately 900 operating on a national or near-national basis. Effective coordination of the activities of such a large number of sellers is difficult if not impossible. Underwriting cycles were moderated in the

75. These percentages are calculated from the data presented in table 11, column (4).

76. In their capacity as members of the research staff of the Academic Task Force, the authors constructed market price indices for several categories of liability insurance. The indices were descriptions of market rates (as opposed to total premiums) and generally showed a lower rate of inflation than that shown in medical malpractice rates.

years prior to the mid-1950s when company-owned rating bureaus were able to establish and enforce rates. A return to that system, however, would raise legitimate antitrust concerns and is out of the question.

No single state represents a sufficiently large part of the national insurance industry to exercise control over these cycles. Theoretically, states could shield doctors from the rate fluctuations that accompany a cycle by requiring insurance carriers to submit both requested rate reductions and rate increases to state regulatory authorities. The result would probably be more stable but higher rates. In addition, such a process is politically unacceptable. A state commissioner of insurance would never call a press conference to announce that she had rejected a company's request to lower medical malpractice premiums for physicians, even if such a step would avoid the traumatic price increases in malpractice premiums experienced the last two years. Such political and economic difficulties would probably confront any similar efforts by the federal government to control the underwriting cycle.

D. RISK CLASSIFICATION SYSTEM

The three factors previously considered—the increase in paid losses, the level of insurance industry profitability, and the underwriting cycle—contribute to the cost and variability of physicians' malpractice insurance. Increased malpractice premiums have not affected all doctors equally, however. Neurosurgeons in some areas of Florida pay nearly \$200,000 annually for malpractice coverage, while family physicians in other areas of the same state pay only \$10,000.⁷⁷ Indeed, medical malpractice became an acute public policy issue during 1985 in large part because of the exorbitant premiums being charged certain specialists, primarily neurosurgeons and obstetricians.

This section analyzes the effect of the risk classification system used by medical malpractice insurers to rate various medical specialists and to determine an appropriate premium for each group of specialists. Two conclusions result from this analysis. First, the number of high-risk specialists insured in some of the risk classes used by insurance companies is too small to provide a sufficient base to absorb the costs of substantial medical injuries. As a result, loss payments in certain high risk specialties have become too large in relation to the number of physicians available to pay for such losses in the narrowly drawn risk classes.

Second, the existing risk classification system does not appear to provide adequate market-based incentives for physicians to avoid

77. See *supra* table 2.

losses. Additionally, the present system does not measure the exposure to loss experienced by individual physicians as accurately as possible. The physician with multiple paid claims is charged the same premium rate as the physician who has never had a paid claim, although past experience may correlate with expected loss payments. Furthermore, a surgeon performing 250 procedures a year pays the same rate as a physician performing a dozen surgeries a year, but her exposure to claims presumably is greater.⁷⁸ A convincing contrary argument can be made, however, that the physician doing occasional surgery poses a greater risk to patients than the surgeon operating on a routine basis. These competing claims need not be resolved here. The assertion is not necessarily that more procedures make a physician more or less of a risk, but only that factors other than specialty—such as past experience with paid claims or greater exposure to claims—should be considered in rating physicians for insurance coverage.

Medical malpractice liability insurance is a financing mechanism by which the cost of administration, determination of liability, and measurement of loss and claims is spread over a group of individuals or organizations. Risk classification enables actuaries to analyze this cost and, in conjunction with senior management of the company, allocate claims costs to groups of risks—in this case physicians. On the basis of some factor or factors, premium differentials among risk groups ultimately are determined. In making these cost allocations, insurers must balance the equity goal of not grouping together physicians with substantially different expected losses (thereby requiring low-risk specialties to subsidize high-risk ones) against the need to constitute a risk class large enough to absorb and spread the cost of anticipated losses. Too small a risk class would not provide enough revenues to cover expected claims. On the other hand, if the risk class is too large, a competing carrier could provide smaller risk classes and lure the most desirable insureds away by offering lower premiums.

The authors reviewed the class plan used by the St. Paul Fire and Marine Insurance Company to insure physicians in Florida. It classifies physicians according to medical specialty and surgical activity and also includes classifications for active military personnel, full-time federal government employees, and retired physicians. In addition to

78. The Tort Reform and Insurance Act of 1986 created a new statute, § 627.6058, which requires that rates reflect the number of surgical procedures performed each year by individual health care providers as well as their claims experience.

TABLE 12
NUMBER OF PRACTICING PHYSICIANS IN FLORIDA: 1975-1986

Specialty	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
Anesthesiology	437	469	579	590	642	703	726	818	807	—	1,003	—
General practice	1767	1986	2167	2239	2414	2541	2497	2800	2696	—	3009	—
General surgery	1057	1068	1162	1154	1218	1267	1276	1331	1422	—	1316	—
Internal medicine	1475	1616	1566	1630	2030	2136	2231	2432	2334	—	2921	—
Neurology & neurosurgery	231	246	263	295	331	337	370	419	446	—	485	—
Obstetrics & gynecology	791	816	913	934	993	1066	1101	1182	1240	—	1334	—
Orthopedics	479	501	560	574	624	632	673	722	758	—	821	—
Otorhinolaryngology	216	217	250	263	277	290	274	296	313	—	323	—
All specialties	10,930	11,600	13,163	13,384	14,496	15,486	15,979	17,103	18,101	—	20,002	—

SOURCE: CENTER FOR HEALTH SERVICES RESEARCH & DEVELOPMENT, ASS'N. PHYSICIAN DISTRIBUTION & MEDICAL LICENSING IN THE U.S. (published annually since 1975 except 1984 & 1986).

NOTE: Data from 1984 and 1986 are not available. Years refer to the calendar year of closing.

specialty ratings, physicians are rated according to whether they practice in urban Dade and Broward Counties or in the remainder of the state. No specific factors are included for the physician's level of activity, i.e., number of patients seen or surgical procedures performed annually, nor is any price adjustment made based on the number and amount of claims incurred by the physician.

As noted above, the size of the financing base available to pay claims depends on the number of insureds practicing a certain specialty within a specified territory of the state. Table 12 shows the total number of physicians practicing in Florida by specialty and illustrates that the financing base may be too small for some of the specialties affected most severely by the medical malpractice crisis. According to the table, only 488 neurosurgeons and neurologists were practicing in Florida in 1985. The actual number of insureds from this total group among whom an individual insurer can spread the costs of expected claims payments is considerably less. Some of those 488 neurosurgeons and neurologists may be self-insured; the remainder will be divided among the several Florida malpractice insurers. Each group of insured neurosurgeons then will be further divided depending upon where in the state they practice.

Current risk classification procedures thus produce tremendous differentials between the relatively modest premiums charged many physicians and the huge premiums charged a few specialists such as neurosurgeons—precisely those physicians who understandably are exerting the most political pressure to reform the tort and insurance systems. Table 13 shows the ratio of premiums for those physicians practicing in three high-risk specialties (orthopedics, obstetrics, and general surgery) to premiums charged a representative low-risk specialty (family physicians). The first table entry, which compares premiums for orthopedists with family physicians in Dade or Broward Counties, indicates that rates charged orthopedists are about seven times those charged family physicians practicing in the same territory. These numbers illustrate the magnitude of the rate differentials resulting from risk classifications.

Figure 4 shows how the relationship between obstetricians' rates and family physicians' rates has changed, i.e., the differential between the rates has increased from 1983 to 1987. Florida Physicians Insurance Company's (FPIC) rates for obstetricians were 8.79 times higher than for family physicians in 1987, compared to 7.28 times higher in 1983. The important point here is that this differential has increased

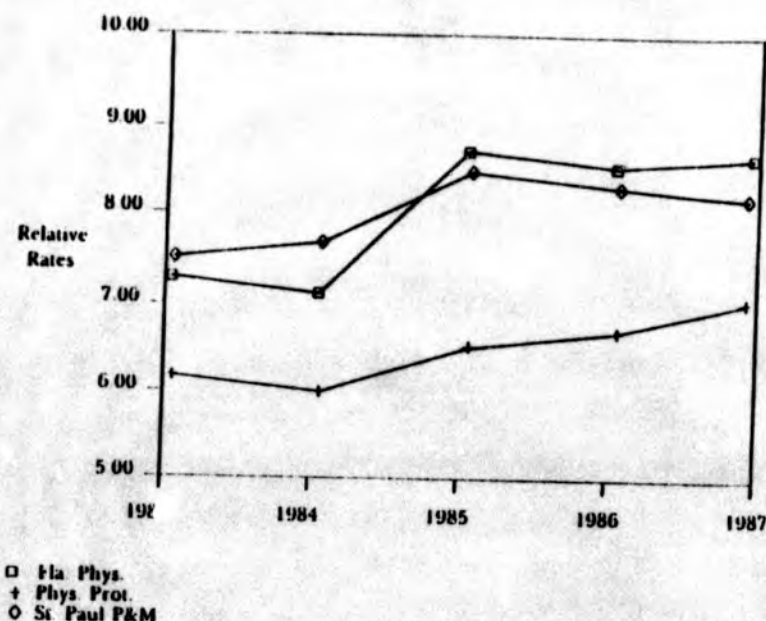
TABLE 13
SELECTED MEDICAL MALPRACTICE RATE RELATIVES: FLORIDA: 1983-1987

	DADE/BROWARD				
	1983	1984	1985	1986	1987
Orthopedics to:					
Family physicians/no surgery					
Florida Physicians Insurance Co.	6.33	6.33	6.72	6.72	7.03
Physicians Protective Trust	6.15	6.33	6.72	6.72	7.03
St. Paul Fire and Marine	6.37	6.55	6.65	6.67	6.69
Obstetrics to:					
Family physicians/no surgery					
Florida Physicians Insurance Co.	7.28	7.28	8.40	8.40	8.79
Physicians Protective Trust	6.13	5.78	6.68	6.83	7.34
St. Paul Fire and Marine	7.41	7.63	8.29	8.33	8.34
General surgery to:					
Family physicians/no surgery					
Florida Physicians Insurance Co.	5.08	5.08	5.04	5.04	5.27
Physicians Protective Trust	6.13	5.78	6.68	6.83	7.34
St. Paul Fire and Marine	5.32	5.46	4.99	5.01	5.03
	REST OF STATE				
	1983	1984	1985	1986	1987
Orthopedics to:					
Family physicians/no surgery					
Florida Physicians Insurance Co.	6.15	6.33	6.72	6.72	7.03
Physicians Protective Trust	6.13	6.21	6.68	6.83	7.34
St. Paul Fire and Marine	6.32	6.48	6.59	6.62	6.65
Obstetrics to:					
Family physicians/no surgery					
Florida Physicians Insurance Co.	7.08	7.28	8.40	8.40	8.79
Physicians Protective Trust	6.13	6.21	6.68	6.83	7.34
St. Paul Fire and Marine	7.36	7.55	8.22	8.26	8.31
General surgery to:					
Family physicians/no surgery					
Florida Physicians Insurance Co.	4.94	5.08	5.04	5.04	5.27
Physicians Protective Trust	6.13	6.21	6.68	6.83	7.34
St. Paul Fire and Marine	5.28	5.41	4.95	4.97	5.00

SOURCE: Florida Department of Insurance, Bureau of Rates

NOTE: The effective dates of the rates used for St. Paul Fire and Marine are as follows: 10/1/83, 9/1/84, 7/1/85, 12/31/85, 7/1/87. The effective dates for rates by Florida Physicians Insurance Co. and Physicians Protective Trust Fund are 1/1 of the respective year. Calculations use rates for mature claims made coverage for \$1,000,000 limit of liability per occurrence and \$3,000,000 annual aggregate. The FPIC has rates 50% higher in Palm Beach County than in the rest of the state.

FIGURE 4
OBSTETRICS PREMIUM DIVIDED BY FAMILY PHYSICIAN/NO SURGERY
PREMIUM FOR DADE/BROWARD COUNTIES: 1983-1987



SOURCE: Table 13.

for all companies. This trend means that risk classification procedures are increasing premiums with a disproportionate increase incurred by those physicians already paying the highest malpractice premiums and most likely to be politically vocal. Some proposed reforms address this issue by limiting the differential between the rates an insurer can charge the high-risk classes and those charged to low-risk classes.⁷⁹

79. Comm. on Insurance, Florida House of Representatives, Reg. Sess., Proposed Comm. Bill INS 87-19 (1987). The proposed bill, commonly referred to as the "Gunter Proposal," provided for no more than a five to one ratio between high premium risk rates and low risk rates. A similar bill, the "Ogden Bill," also provided that "premiums under the plan for the highest risk class of physicians shall not exceed five times the rate for the lowest risk class," with a cap on the rates of the high risk specialists. H.R. 1458, Comm. on Insurance, Florida House of Representatives, Reg. Sess. (1987).

TABLE 14

TERRITORIAL RATE DIFFERENCES IN FLORIDA FOR SELECTED MEDICAL SPECIALTIES IN DADE/BROWARD COMPARED TO REST OF THE STATE: 1983-1987

	1983	1984	1985	1986	1987
Family physicians/no surgery					
Florida Physicians Insurance Co.	1.41	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.47	1.50	1.50	1.50
St. Paul Fire and Marine	1.49	1.18	1.48	1.49	1.97
General surgery					
Florida Physicians Insurance Co.	1.45	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.37	1.50	1.50	1.50
St. Paul Fire and Marine	1.50	1.50	1.50	1.50	1.99
Orthopedics					
Florida Physicians Insurance Co.	1.45	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.37	1.50	1.50	1.50
St. Paul Fire and Marine	1.50	1.50	1.50	1.50	1.99
Obstetrics					
Florida Physicians Insurance Co.	1.45	1.45	1.50	2.00	2.00
Physicians Protective Trust	1.25	1.37	1.50	1.50	1.50
St. Paul Fire and Marine	1.50	1.50	1.50	1.50	1.99

SOURCE: Florida Department of Insurance, Bureau of Rates.

NOTE: The rates used for St. Paul Fire and Marine are as follows: 10/1/83, 9/1/84, 7/1/85, 12/31/85, 7/1/87. The effective dates of the rates for Florida Physicians Insurance Co. and Physicians Protective Trust Fund are 1/1 of the respective year. Calculations use rates for mature claims made coverage for \$1,000,000 limit of liability per occurrence and \$3,000,000 annual aggregate. The FPIC has rates 50% higher in Palm Beach County than in the rest of the state.

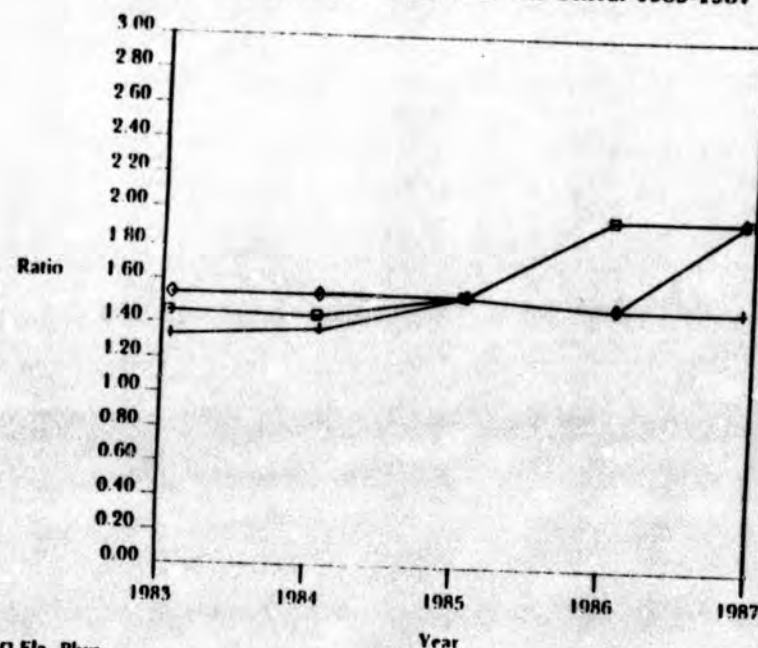
In addition to substantial rate differentials by specialty, malpractice premiums also vary considerably from one geographic rating territory to another. As noted in the introduction, the sense of crisis concerning medical malpractice that exists in Florida is concentrated in the urban areas surrounding Miami and Fort Lauderdale.⁸⁰ During recent years, the rate differential for physicians practicing in these areas relative to the rest of the state has increased. Table 14 compares the rates charged in Dade and Broward Counties with those in the rest of the state. The first entry in table 14 indicates that in 1983 the FPIC charged family physicians in urban Dade and Broward Counties 41% more than it charged family physicians in the rest of the state. By July 1, 1987, the FPIC was charging twice as

80. See *supra* notes 9-11 and accompanying text (describing south Florida as "The Beirut" of medical malpractice crisis).

much in Dade and Broward Counties as in the rest of the state. These ratios which compare rates in the two rating territories, are graphed in figure 5.

FIGURE 5

OBSTETRICS PREMIUMS IN DADE/BROWARD COUNTIES COMPARED TO OBSTETRICS PREMIUMS IN THE REST OF THE STATE: 1983-1987



□ Fla. Phys.
+ Phys. Prot.
◇ St. Paul F & M

SOURCE: Table 14

This section has discussed the factors used to categorize physicians into risk classes and the size of the resulting risk classes. In the last decade, paid losses have increased substantially faster than the number of physicians available to pay them, which has led to an inexorable rise in premiums. In addition, the extra amount charged high-risk specialties compared to low-risk groups has increased, as has the surcharge for physicians in Dade and Broward Counties. The risk classification plans in use during the period studied made no specific provision for experience rating, i.e., those physicians who had paid claims incurred no specific surcharges. Thus, no market price incentives existed in the standard insurance market for the person best able to control losses—the physician.

IV. THE NATURE OF INCREASED CLAIMS COSTS: FURTHER EXAMINATION OF FLORIDA CLOSED CLAIMS

The previous section concludes that increased claims costs are the primary cause of the dramatic increase in medical malpractice premium rates during the past five years. The detailed information available about Florida claims for the past twelve years enables the authors to determine what is driving this tremendous increase in claims costs. Is it the frequency of claims? Do physicians face, as is sometimes alleged, a substantially greater number of claims—a greater frequency—than previously? Or is the spectacular rise in total loss payments attributable primarily to an increase in the size—or severity—of the loss payments? Finally, do the closed claims data shed any light on the assertion that the medical malpractice crisis is largely the result of "bad doctors" and not a product of deficiencies in the tort and insurance systems?

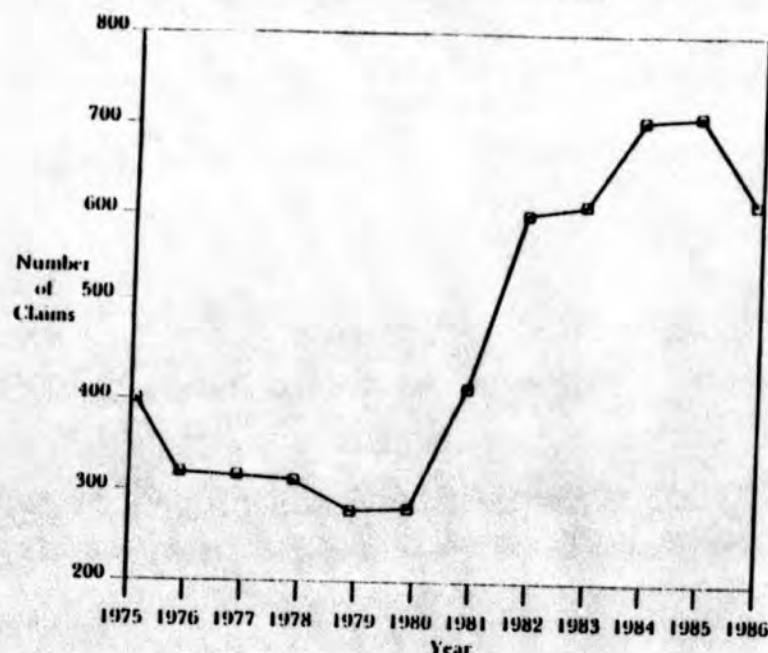
These questions are addressed in this section through a detailed analysis of the closed claims data collected by the Florida Department of Insurance. An understanding of the nature of the increase in total loss payments is crucial, because different remedies may be warranted depending on what drives the increased costs. If total costs are rising because of an increasing frequency of claims, then solutions include finding ways to reduce both the number of iatrogenic (physician-induced) injuries and the incentives for making claims, and to control the conditions and circumstances under which liability is assessed against physicians or hospitals. If the rise in the cost of each incident is responsible for increased loss payments, then solutions include methods of reducing the severity of medical injuries and the costs resulting from medical injuries, and controlling the amount of jury awards and settlements. When increased frequency and severity are both causing increased costs, a more complex package of changes may be necessary to affect loss payments substantially.

A. INCREASED CLAIMS FREQUENCY

This subsection examines the trend in the number of insurance claim files that have been closed in the last twelve years in Florida. Over this substantial period, the frequency of closed claims should reflect accurately the burdens imposed on the tort and insurance systems by medical malpractice claims. The frequency of closed claims, however, is not a perfect indication of the propensity to file medical malpractice claims. For one thing, a lag time of one to five years typically exists between the time a file is opened and the time it is closed. Accordingly, any dramatic surge in the number of medical malpractice claims filed in 1987 would not be completely reflected in the closed claims data until the 1990s. Furthermore, the number of

FIGURE 6

NUMBER OF MEDICAL MALPRACTICE CLAIMS IN FLORIDA INVOLVING AN INDEMNITY PAYMENT: 1975-1986



SOURCE: Florida Department of Insurance medical malpractice closed claims data set.

closed claims is a function not only of the number of filed claims, but also of the propensity of insurers to close claims. For example, insurers may be more reluctant to immediately pay claims during a time when interest rates are high because they may benefit from investing premium dollars longer and by delaying payment. And local changes in the law may make it disadvantageous for either the insurance carrier or the plaintiff to settle a case during a certain period. Accordingly, it is more accurate to look at frequency trends over the entire period of time for which closed claims data are available—twelve years—than to focus on trends during one portion of that period.

Without any adjustment for changes in the number of physicians practicing in the state or for population growth, the number of closed claims in Florida during the period 1975 through 1986, as illustrated in figure 6, increased at a rate of approximately 4.6% per year. Examination of these changes shows a steady decline, at an annual compound rate of 12.5%, in the number of claims closed between 1975 and 1979, followed by a sharp increase between 1979 and 1986,

at an annual compound rate of 15.9%. The 1986 figure was significantly lower than that for 1985, but this was due partially to a lengthening of the time between the event giving rise to the claim and the settlement or disposition date. Consequently, nothing presently indicates that the number of claims will either stabilize or continue to decline.

The decline in the number of closed claims from 1975 to 1979 was probably caused by Florida's enactment in 1975 of legislation requiring mediation of medical malpractice claims to control the cost of claims by reducing the adversarial nature of the claims settlement process.⁸¹ From the beginning the constitutionality of the mandatory mediation provision was challenged,⁸² creating uncertainty for the plaintiffs bar as to whether to accept a mediated award or wait in the expectation that the mediation requirement would be declared unconstitutional. As a result, the average time to resolve a claim increased. In 1980, the mediation rule was eliminated,⁸³ and the surge in claims in the early 1980s was due in large part to the processing of these earlier cases. This analysis of the effect of the mandatory mediation rule suggests that the period 1975 through 1982 should probably be viewed in its entirety without focusing on annual changes. Seen in this light, the claims rate is relatively stable during this time with, perhaps, a slight upward trend.

Any attempt to trend claim frequency without adjusting for increases in population, increases in the number of physicians, or other factors that may influence the number of physician-patient contacts does not suggest anything about the claims propensity of injured patients. Since 1975, Florida's population has increased 35%—from 8.6 million in that year to 11.7 million in 1986.⁸⁴ Part of the increase in the number of claims filed and paid is due to this population growth. Increases in frequency beyond that attributable to population growth may be caused by an increase in the iatrogenic injury rate, an increased claims propensity on the part of the general public, or other factors. Table 15 shows the number of claims closed each year in Florida from 1975 through 1986 for which an indemnity payment was made. This figure was divided by the state's population to obtain the claims rate per 100,000 people. During this period, an average of 4.51 claims were paid each year per 100,000 people. An upward trend in claims frequency persisted, even after adjusting for

81. 1975 Fla. Laws ch. 75-9.

82. In *Aldana v. Holub*, 381 So. 2d 231, 236 (Fla. 1980), the Florida Supreme Court held § 768.44, establishing medical liability mediation panels, unconstitutional as violative of the due process clauses of the state and federal constitutions.

83. The legislature formally repealed the statute in 1983. 1983 Fla. Laws ch. 83-214.

84. BUREAU OF ECONOMIC & BUSINESS RESEARCH, COLLEGE OF BUSINESS, UNIV. OF FLA., 1987 FLORIDA STATISTICAL ABSTRACT 15 (July 1987). The 1975 population estimate was obtained from the 1980 edition of the abstract (July 1986).

population change, although at a much more modest rate. Overall, the growth rate in claims per 100,000 people from 1975 to 1986 was 1.8% per year.

The frequency of claims also was analyzed by adjusting for the increased number of physicians practicing in Florida.⁸⁵ During the period that Florida's population increased by 35%, the number of physicians practicing in the state grew by 95% (see table 16). As a result of this relatively greater growth in the number of physicians compared to population, the closed claims rate per physician has remained virtually unchanged from 1975 to 1986.

The trend in frequency of claims per physician — and indeed the frequency of claims per physician itself — however, varies markedly from specialty to specialty. Table 17 shows that for all specialties, the average number of paid claims per 100 physicians per year was 2.75 from 1975 through 1985. Over the entire eleven-year period, an obstetrician was 92% more likely to have a claim closed against her than the average physician in Florida, and neurologists faced a 125% higher risk than the average physician. In recent years, the differentials for these specialties have been even greater.

Table 18 displays the proportion of claims closed by specialty with the specialties ranked in descending order according to the proportion of claims closed over the entire period. The last two columns show the contribution each specialty has made to the total number of claims. Obstetrics and gynecology account for about 14% of all indemnity claims over the entire period, followed by general practice, general surgery, orthopedics, and internal medicine. These five specialties collectively account for over one-half of the claims in which indemnity was paid. For the five major specialties mentioned above, the proportion of the total number of claims accounted for by general practice and general surgery has declined since 1975, and the proportion of claims from internal medicine has remained relatively stable. Significantly, obstetrics and gynecology and orthopedics represent an increasing proportion of an increasing number of claims.

Because there were tremendous differences between the level of malpractice premiums charged in the two geographical rating territories in Florida—Dade and Broward Counties and the rest of the state—it should come as no surprise that substantial differences exist in the frequency of claims per 100,000 population between various

85. CENTER FOR HEALTH SERVICES RESEARCH & DEV., AM. MEDICAL ASS'N, PHYSICIAN DISTRIBUTION & MEDICAL LICENSING IN THE U.S. (published annually since 1975 except 1984 & 1986).

TABLE 15
MEDICAL MALPRACTICE CLOSED CLAIMS (INDEMNITY CLAIMS ONLY) PER 100,000 OF POPULATION:
FLORIDA COUNTIES WITH 1986 POPULATIONS GREATER THAN 250,000

County	Mean	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
Broward	8.36	6.73	4.92	5.53	4.83	4.05	4.91	7.83	11.15	12.68	13.90	11.74	12.01
Dade	6.51	6.82	6.16	4.95	6.09	3.26	3.31	6.46	8.04	5.17	10.36	7.43	6.81
Orange	5.59	6.88	5.76	7.06	6.68	2.82	2.76	4.15	6.06	5.52	7.35	5.95	6.06
Hillsborough	4.87	3.64	4.15	4.13	2.76	2.85	1.85	5.29	4.72	5.05	7.20	6.73	7.09
All of Florida	4.51	4.51	3.92	3.74	3.31	2.41	2.63	4.38	3.55	5.72	6.19	6.21	3.49
Pinellas	4.34	5.69	3.39	3.20	3.28	2.24	2.88	4.31	5.95	6.91	6.26	4.30	3.43
Palm Beach	4.27	3.32	4.93	4.43	2.14	1.84	3.12	3.25	5.80	6.90	5.13	4.91	5.45
Duval	4.25	7.04	3.33	2.82	2.29	2.63	4.55	6.08	4.31	4.60	4.62	4.63	4.03
Sarasota	4.01	2.43	4.80	4.64	3.29	3.10	0.99	3.82	4.18	5.82	2.16	6.30	6.34
Volusia	3.46	1.83	4.02	0.87	2.94	2.02	1.93	5.22	3.61	4.92	3.72	3.58	6.90
Polk	3.16	3.10	3.39	3.34	2.31	1.26	2.80	3.02	5.31	2.32	2.81	6.83	1.59
Pasco	2.95	2.82	3.35	3.21	0.61	1.69	1.55	2.44	3.78	4.13	1.77	5.37	4.40
Brevard	2.94	4.05	4.91	0.80	2.74	1.14	1.10	1.42	3.60	2.59	2.17	5.90	4.70
Lee	2.41	—	0.61	0.59	1.10	2.59	1.46	2.93	4.84	2.12	1.09	4.92	3.97
Escambia	1.78	—	0.44	1.74	2.17	1.29	0.43	0.84	1.63	2.00	0.72	5.67	2.56

SOURCE: Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

NOTE: Years refer to the calendar year of closing.

TABLE 16
ADJUSTED MEDICAL MALPRACTICE CLOSED CLAIMS RATES IN FLORIDA: 1975-1986

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
Number of indemnity claims (all specialties)	389	343	334	303	228	256	443	376	606	677	708	640
Population (Florida) (000s) ¹	8,619	8,744	8,920	9,157	9,449	9,747	10,106	10,375	10,592	10,930	11,288	11,635
Number of practicing physicians ²	10,930	11,600	13,163	13,584	14,498	15,486	15,979	17,105	18,101	†	20,002	†
Claims rate per 100,000 people	4.51	3.92	3.74	3.31	2.41	2.63	4.38	5.55	5.72	6.19	6.27	5.49
Claims rate per 1,000 physicians	3.56	2.96	2.54	2.23	1.57	1.65	2.77	3.37	3.35	N/A	3.54	N/A

SOURCE:

¹ Florida Department of Insurance Closed Claims Data Set.

² BUREAU OF ECONOMIC & BUSINESS RESEARCH, COLLEGE OF BUSINESS, UNIV. OF FLA., 1987 FLORIDA STATISTICAL ABSTRACT (1975-1986 eds.).

³ CENTER FOR HEALTH SERVS. RESEARCH & DEV., AM. MEDICAL ASS'N, PHYSICIAN DISTRIBUTION & MEDICAL LICENSING IN THE U.S. (published annually since 1975 except 1984 and 1986).

NOTES:

† Figures not reported by the American Medical Association.

TABLE 17
NUMBER OF MEDICAL MALPRACTICE PAID CLAIMS PER 100 PHYSICIANS IN FLORIDA: 1975-1986

Specialty	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	All Years
Anesthesiology	5.72	5.33	1.73	2.20	0.62	1.56	2.34	4.16	4.91	-	2.89	-	3.15
General practice	3.96	2.87	3.05	1.38	1.57	1.14	2.12	1.89	2.45	-	2.23	-	2.27
General surgery	6.05	5.45	4.30	4.51	2.22	1.80	3.61	5.26	3.80	-	4.20	-	4.14
Internal medicine	1.96	0.74	1.28	0.60	0.50	0.75	1.03	1.76	1.82	-	1.61	-	1.21
Neurology & neurosurgery	6.06	2.85	3.89	4.03	2.11	2.67	6.22	5.25	4.48	-	3.53	-	4.31
Obstetrics & gynecology	5.31	5.02	5.81	4.71	3.42	3.68	4.90	5.25	6.73	-	8.05	-	5.29
Orthopedics	6.68	6.39	4.82	3.31	4.17	3.37	5.79	8.31	8.71	-	9.99	-	6.15
Otorhinolaryngology	5.09	6.91	3.47	1.89	0.36	2.76	6.57	5.41	4.76	-	4.31	-	4.15
All specialties	3.56	2.96	2.54	2.23	1.57	1.65	2.77	3.37	3.35	-	3.54	-	2.75

SOURCE: Florida Department of Insurance Medical Malpractice Closed Claims Data Set (for number of claims); CENTER FOR HEALTH SERVS. RESEARCH & DEV., AM. MEDICAL ASS'N, PHYSICIAN DISTRIBUTION & MEDICAL LICENSING IN THE U.S. (published annually since 1975 except 1984 & 1986) (for number of physicians).

NOTE: Years refer to the calendar year of closing.

TABLE 18
PROPORTION OF MEDICAL MALPRACTICE CLAIMS CLOSED IN FLORIDA: 1975-1986

Specialty	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	Total % 1975-1986	Cumulative % of Total
Obstetrics & gynecology	10.8	12.0	15.9	14.5	14.9	15.2	12.2	10.8	13.9	15.4	15.4	13.1	13.63	13.63
General practice	18.0	16.6	19.8	10.2	16.7	11.3	12.0	9.2	10.9	8.3	9.5	13.3	12.19	25.82
General surgery	16.5	16.9	15.0	17.2	11.8	9.4	10.4	12.3	8.9	9.9	9.2	8.9	11.54	37.36
Orthopedics	8.2	9.3	8.1	6.3	11.4	8.6	8.8	10.4	10.9	9.5	11.0	12.5	9.98	47.34
Internal medicine	7.5	3.5	7.2	3.6	5.3	6.3	5.2	7.5	7.6	8.1	6.6	7.3	6.63	53.97
Emergency room	0.8	0.6	1.6	4.6	8.8	8.6	8.8	6.9	5.9	7.6	5.6	3.6	3.63	50.60
Osteopathy	6.2	3.2	1.5	6.3	6.6	12.1	7.4	7.3	5.8	4.3	4.1	0.0	4.96	64.56
Anesthesiology	6.4	7.3	3.0	4.3	1.8	4.3	3.8	5.9	7.3	6.5	4.1	2.7	4.96	69.53
Radiology & roentgenology	4.9	3.5	5.4	3.0	3.5	4.3	5.0	4.0	5.9	4.9	6.1	5.3	4.87	74.40
Neurology & neurosurgery	3.6	2.0	3.3	4.0	3.1	3.5	5.2	3.8	3.3	3.1	3.8	2.7	3.45	77.85
Pediatrics	2.3	3.8	2.4	3.6	2.2	1.6	4.3	5.2	2.1	2.1	4.1	3.6	3.31	81.16
Plastic surgery	2.8	5.6	2.7	3.6	1.8	2.7	2.0	2.6	3.0	2.5	3.4	3.1	3.00	84.15
Otorhinolaryngology	2.6	4.4	2.7	1.7	0.4	3.1	4.1	2.8	2.5	3.5	2.0	2.8	2.80	86.95
Cardiovascular	2.3	1.5	1.8	2.3	1.6	0.4	2.7	1.0	3.1	2.1	3.0	4.7	2.44	89.39
Urology	1.3	1.2	3.9	1.7	3.1	4.3	1.4	1.6	2.6	2.4	2.7	2.0	2.25	91.64
Ophthalmology	1.3	2.9	0.6	1.7	0.9	2.3	0.7	1.6	2.5	2.4	1.7	2.2	1.80	93.44
Dermatology	1.8	0.6	2.7	7.3	3.5	0.0	1.8	2.1	1.7	1.6	1.0	0.3	1.78	95.22
Thoracic surgery	1.0	2.3	0.6	1.0	0.9	0.4	1.8	0.9	0.3	1.3	1.0	1.6	1.11	96.33
Pathology	0.0	0.3	0.6	0.3	0.4	1.6	1.4	0.9	0.3	1.0	1.8	1.6	0.94	97.27
Gastroenterology	0.0	0.3	0.0	1.0	0.0	0.0	0.0	1.0	0.5	1.0	1.3	1.6	0.71	97.98
Not classified	0.0	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	4.7	0.63	98.64
Psychiatry	0.8	0.6	0.9	1.3	0.4	0.0	0.5	0.2	0.0	0.3	0.4	0.5	0.44	99.07
Nephrology	0.0	0.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.0	0.5	0.20	99.27
Endocrinology	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.8	0.0	0.3	0.0	0.16	99.44
Proctology	0.0	0.0	0.0	0.7	0.4	0.0	0.2	0.0	0.2	0.0	0.1	0.0	0.11	99.55
Allergy	0.0	0.3	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.1	0.4	0.0	0.11	99.65
Hematology	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.5	0.09	99.75
Physical medicine & rehabilitation	0.3	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.1	0.0	0.3	0.09	99.84
Pulmonary disease	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.07	99.91
Oncology	0.3	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.05	99.96
Public health	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.02	99.98
Rheumatology	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.02	100.00
Totals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	

SOURCE: Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

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counties in the state. Four urban counties had a claims frequency above the state average: Broward (Fort Lauderdale), Dade (Miami), Orange (Orlando), and Hillsborough (Tampa). For the most recent three years, the frequency of claims per 100,000 population in Broward County is more than twice as great as the statewide average, and the Dade County frequency also is substantially above the statewide average. Moreover, the closed claims frequency is increasing rapidly for Broward County.

The premium rate differential between the two geographical rating territories appears justified based upon the closed claims analysis of claims frequency. Indeed, if only frequency data is considered, an even higher differential in rates between Dade/Broward Counties and the rest of Florida may be justified.

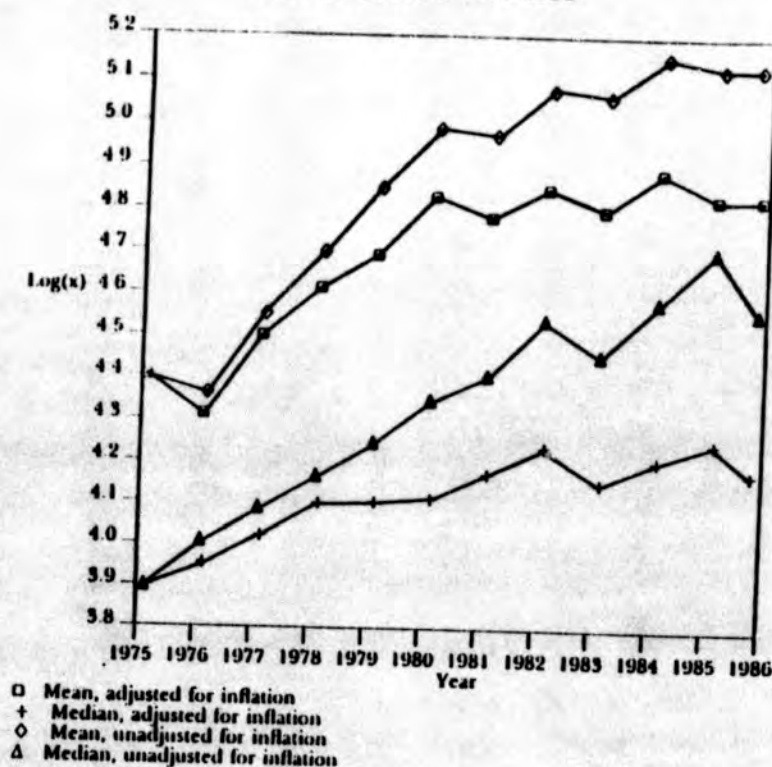
B. INCREASED CLAIMS SEVERITY

The total paid claims in a given year equals the number of claims paid (frequency) times the cost per claim (severity). The previous section describes trends in the frequency of Florida's closed claims; this section analyzes trends in the cost of those claims in which an indemnity payment was made. The rate of increase in severity (size) of payments has been much greater than the rate of increase in frequency. Consequently, the increase in total paid claims is due more to growth in severity than growth in frequency. Stated differently, larger insurance company settlements and larger verdicts are more important causes of increased medical malpractice insurance rates than the higher number of claims.

The closed claim data demonstrate that the increase in average claim size results both from an increase in the proportion of very large paid claims and, to a lesser extent, from a rise in the proportion of paid claims in the medium-to-large category. This section also compares the size of paid claims in urbanized south Florida with the average claim severity for the rest of the state. While average claims frequency for the Miami and Fort Lauderdale metropolitan areas was almost twice as high as for the rest of the state, severity averaged only about 15% more than the rest of the state. During the most recent three years, however, average claim severity rose more dramatically in south Florida than in the remainder of the state. In other words, people in Dade and Broward Counties seem to have been more claims conscious than people in the rest of the state during the entire 1975 to 1986 period, but the average cost of paid claims accelerated relative to the rest of the state only recently.

FIGURE 7

MEAN AND MEDIAN PAID MEDICAL MALPRACTICE CLAIMS IN FLORIDA FOR ALL SPECIALTIES: 1975-1986



SOURCE: Calculated from the Florida Department of Insurance medical malpractice closed claims data set.

NOTE: This graph plots the natural logarithm of each number to show that the growth rates of both the average and the median are high (the steeper the slope of the line, the higher the growth rate).

1. Average and Median Costs Per Claim

Figure 7 illustrates the changes in the average and median costs per claim for all medical specialties since 1975 in Florida. When discussing the "average" amount of claims payments, the figures vary dramatically depending upon whether means or medians are used. The mean of a group of claims payments is determined by adding the amounts of all the claims payments and then dividing this total by the number of payments. The median size claim is simply the middle number obtained when all claims are arranged in order from the

highest amount to the lowest amount. The median is a useful measure of the rate of cost increase because it is not influenced disproportionately by a few very large or very small claims. For rate-setting purposes, however, the mean claim should be used because the mean and the frequency of paid claims determine the total outlay of insurers.

The closed claims survey data from Florida show that mean claims severity increased at an annual compound rate of 14.6% from 1975 through 1986. Table 19 shows the mean and median claims costs for malpractice claims arising in selected specialties in Florida for various years since 1975. Many cases in this table illustrate the extent to which the average (mean) cost of a paid claim has increased, but only a few will be discussed here. Pediatrics provides the most striking example of what has happened in Florida, because the average cost of a claim in this specialty has increased over \$300,000 from 1975 to 1986. This corresponds to an annual compound growth rate of 18.5%; that is, the average cost of a pediatrics claim was doubling approximately every 3.9 years during the period studied. Other major specialties with a substantial increase in the average claims cost during the same period were neurology (increase of \$194,000), anesthesiology (increase of \$180,000), and obstetrics and gynecology (increase of \$161,000). None of the major specialties showed a decrease in average claims cost during the period studied.

Even when the average costs per claim were adjusted for the effects of inflation, they still exhibited substantial growth during the 1975 to 1986 period. Table 20 indicates the inflation-adjusted mean and median cost per claim by specialty, as well as the mean and median cost for all claims. After eliminating the effect of inflation on paid claims, the average cost of a paid claim increased at a compound rate of 7.6% per year.

The upward trend in cost is apparent in the size of the median claim as well as the average claim. The median claim size increased from \$7,500 in 1975 to \$30,000 in 1986. Overall, the average annual growth rate in this number has been 13.4%, a number substantially in excess of the inflation rate.

2. Impact of Changes In Loss Size Distribution Upon Average Cost

Increases in the size of the average claim naturally lead to questions about what caused the increase. Was it simply a few extremely large claims that drove up the average cost or was it due to a greater

TABLE 19

MEAN AND MEDIAN MEDICAL MALPRACTICE CLAIMS IN FLORIDA
SELECTED YEARS

Specialty	1975	1980	1984	1985	1986	Change 1975-1986
Anesthesiology						
Mean	\$43,014	\$137,954	\$225,928	\$144,579	\$222,683	\$179,669
Median	15,000	70,000	27,500	57,500	66,650	51,650
Cardiology						
Mean	18,144	162,500	86,849	140,106	60,473	42,329
Median	7,500	162,500	29,584	50,000	25,000	17,500
Emergency						
Mean	3,517	74,131	73,678	71,093	55,485	51,968
Median	1,800	13,750	15,000	10,000	8,500	6,700
General practice						
Mean	16,768	94,560	103,734	149,571	81,296	64,528
Median	5,000	25,000	35,000	55,000	25,000	20,000
General surgery						
Mean	26,142	40,262	83,338	98,351	79,704	53,562
Median	10,000	11,250	30,000	37,500	37,500	27,500
Internal						
Mean	40,141	45,885	170,095	173,669	132,611	92,470
Median	12,000	16,250	35,000	75,000	32,500	20,500
Neurosurgery						
Mean	34,352	25,867	468,424	192,095	228,220	193,868
Median	12,000	10,000	40,000	50,000	100,000	88,000
OB/GYN						
Mean	14,173	96,261	167,533	168,759	174,728	160,555
Median	5,500	28,500	48,588	40,000	40,000	34,500
Orthopedics						
Mean	21,822	73,396	147,838	121,238	116,904	95,082
Median	12,500	26,476	30,000	46,500	25,000	12,500
Osteopathy						
Mean	33,899	96,388	209,362	91,933		(33,809)
Median	12,125	37,500	60,000	50,000		(12,125)
Pediatrics						
Mean	55,738	27,393	382,485	102,539	359,779	304,041
Median	20,000	4,750	65,000	20,000	63,028	43,028
Psychiatry						
Mean	26,083		13,750	39,333	31,945	5,862
Median	20,000		13,750	50,000	33,334	13,334
Radiology						
Mean	36,055	146,781	122,289	109,085	149,293	113,238
Median	2,500	27,390	30,000	35,000	10,833	8,333
Thoracic						
Mean	84,375	9,130	102,130	56,107	243,278	158,903
Median	36,250	9,130	25,000	12,500	137,500	101,250

SOURCE: Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

NOTE: Figures include paid claims only and are unadjusted for inflation.

TABLE 20

INFLATION-ADJUSTED MEAN AND MEDIAN MEDICAL MALPRACTICE
CLAIMS IN FLORIDA: SELECTED YEARS

Specialty	1975	1980	1984	1985	1986	Change 1975-1986
Anesthesiology						
Mean	\$43,014	\$90,106	\$117,067	\$72,334	\$109,307	\$66,293
Median	15,000	45,721	14,249	28,768	32,716	17,716
Cardiology						
Mean	18,144	106,139	45,002	70,096	29,684	11,540
Median	7,500	106,139	15,329	25,016	12,272	4,772
Emergency						
Mean	3,517	48,419	38,177	35,569	27,236	23,719
Median	1,800	8,981	7,772	5,003	4,172	2,372
General practice						
Mean	16,768	61,763	53,751	74,832	39,905	23,137
Median	5,000	16,329	18,156	27,517	12,272	7,272
General surgery						
Mean	26,142	26,298	43,182	49,206	39,124	12,982
Median	10,000	7,348	15,545	18,762	18,407	8,407
Internal						
Mean	40,141	29,970	88,136	86,889	65,094	24,953
Median	12,000	10,614	18,135	37,523	15,953	3,953
Neurosurgery						
Mean	34,352	16,895	242,719	96,107	112,025	77,673
Median	12,000	6,532	20,726	25,016	49,086	37,086
OB/GYN						
Mean	14,173	62,874	86,809	84,432	85,768	71,595
Median	5,500	18,615	25,073	20,012	19,635	14,135
Orthopedics						
Mean	21,822	47,939	76,604	60,657	57,384	35,542
Median	12,500	17,293	15,545	23,264	12,272	(2; 8)
Osteopathy						
Mean	33,899	62,957	108,483	45,995		(33,899)
Median	12,125	24,494	31,090	25,016		(12,125)
Pediatrics						
Mean	55,738	17,892	198,189	51,301	176,603	120,865
Median	20,000	3,103	33,680	10,006	30,938	10,938
Psychiatry						
Mean	26,083		7,125	19,679	15,681	(10,402)
Median	20,000		7,125	25,016	16,362	(3,638)
Radiology						
Mean	36,055	95,871	63,366	54,576	73,283	37,228
Median	2,500	17,890	15,545	17,511	5,317	2,817
Thoracic						
Mean	84,375	5,963	52,920	28,071	119,417	35,042
Median	36,250	5,963	12,954	6,254	67,494	31,244

SOURCE: Florida Department of Insurance medical malpractice closed claims data set.

NOTE: Figures include paid claims only and are in 1975 dollars.

number of slightly larger than average claims? Past research efforts generally have been unable to answer this question due to a lack of data. Such was not the case in the present study. Because of actions taken by the Florida Legislature in the mid-1970s,⁸⁶ the Florida Department of Insurance was able to supply data enabling the authors to determine the cost of virtually every medical malpractice claim closed in Florida since 1975. Using this data it was possible to analyze where the cost increases occurred.

The analysis shows that both of the factors noted above caused the average cost to increase. Not only did the number and size of large paid claims increase, but there was also a greater proportion of the number of paid claims in the medium-to-large size category. The first part of table 21 displays the largest paid claim in Florida for each year from 1975 to 1986. The results are dramatic but probably not surprising to those who have been closely involved with the medical malpractice problem. In 1976 the largest claim was \$500,000, followed by a trend during the intervening years of almost uninterrupted growth as shown in figure 8. The remainder of table 21 is a year-by-year analysis of large claims. For any given year, it shows the number of claims in excess of specified dollar amounts, including \$250,000, \$500,000, \$1,000,000 and various other levels of payments. The table illustrates that prior to 1980 there were no paid claims in excess of \$1,000,000; however, by 1986 there were twelve paid claims each in excess of \$1,000,000. In table 21, the figure in parentheses below the number of claims is the percentage which that number represents of the total number of claims closed in that year. When the aggregate dollar amount of claims paid is examined, the increased effect of large claims also is dramatic. Million dollar plus claims represented 4.9% of the total amount of paid claims in 1981.⁸⁷ By 1986, the amount paid for these few claims (less than 1% of the number of claims) accounted for 29.1% of the total compensation paid.

The increase in the proportion of total claims that fall into the "medium-to-large" category can be measured by comparing the data for various years presented in table 22. Cost shifts caused by more frequent payments of larger claims can be detected by noting a declining percentage in smaller dollar categories. Table 22 shows that in 1975, 90.39% of the number of paid claims were for \$25,000 or less; but that by 1986, this percentage of small claims had fallen to 76.96%.

86. See *supra* notes 45-47 and accompanying text (describing legislation requiring filing of closed claim information).

87. Analysis of Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

TABLE 21
ANALYSIS OF LARGE MEDICAL MALPRACTICE CLAIMS IN FLORIDA: 1975-1986

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
Largest paid claim (\$000)	\$500	\$500	\$950	\$850	\$600	\$960	\$1,624	\$2,530	\$1,536	\$5,114	\$3,045	\$4,000
Number of paid claims greater than												
\$250,000	5 (0.52)	2 (0.19)	3 (0.22)	8 (0.55)	12 (0.82)	21 (1.31)	31 (1.53)	70 (2.99)	75 (2.96)	102 (3.73)	94 (5.34)	62 (4.26)
\$500,000			2 (0.15)	1 (0.07)	3 (0.21)	6 (0.38)	10 (0.49)	33 (1.25)	31 (1.22)	46 (1.68)	30 (1.70)	29 (1.99)
\$750,000			2 (0.15)	1 (0.07)	5 (0.31)	4 (0.31)	21 (0.20)	18 (0.79)	31 (0.71)	15 (1.13)	19 (0.85)	11 (1.51)
\$1,000,000						1	5 (0.05)	1 (0.19)	12 (0.28)	9 (0.44)	12 (0.51)	8 (0.83)
\$1,500,000							1 (0.05)	1 (0.04)	1 (0.04)	10 (0.37)	5 (0.28)	8 (0.55)
\$2,000,000								1 (0.04)		3 (0.11)	3 (0.17)	2 (0.14)
\$3,000,000											1 (0.06)	1 (0.07)
\$4,000,000												
\$5,000,000												
Number of claims closed	968	1036	1335	1453	1457	1597	2032	2644	2536	2793	1760	1434

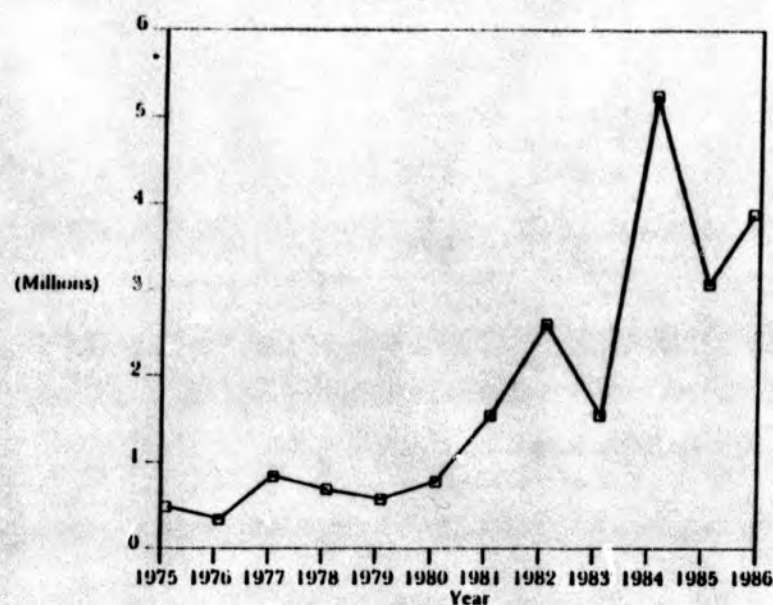
Source: Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

Key: Open figures are the number of claims. Figures in parentheses () represent the percent of the number of claims closed that year.

Although the percentage of paid claims less than \$25,000 declined more than any other category of claim size, reductions were also noted in the percentage of claims settled for amounts of \$100,000 or less, and for claims paid in amounts of \$300,000 or less.

FIGURE 8

**TREND IN LARGEST MEDICAL MALPRACTICE PAID CLAIMS IN FLORIDA:
1975-1986**



SOURCE: Table 31

In summary, a general increase in the number and proportion of claims in all larger size categories has occurred, which has caused the overall cost of an average claim to rise. The effect of the increase in the number and size of the very large claims, however, has been most important. There has been a dramatic increase in the size of the largest claim and an equally dramatic increase in the frequency of large claims.

3. Differences in Size of Loss Payments Between Urban and Non-Urban Areas

An analysis of Florida closed claims during the period 1975 through 1986 demonstrates significant differences in the average size of claims payments among various areas of the state, just as the

TABLE 22
**CUMULATIVE PROPORTION OF THE NUMBER OF MEDICAL MALPRACTICE CLAIMS
CLOSED IN FLORIDA ACCORDING TO SIZE: 1975-1986**

Claim Size: Zero Through	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
\$25,000	90.39	92.09	91.84	93.12	94.10	95.05	89.67	88.96	88.37	86.86	77.39	76.96
\$50,000	94.53	96.24	95.43	95.39	96.02	94.74	92.67	91.30	91.17	90.61	82.44	83.29
\$75,000	96.07	97.59	96.78	96.49	97.05	96.12	94.14	92.55	92.63	92.39	85.17	86.31
\$100,000	98.55	98.94	99.03	98.42	98.35	97.31	96.56	94.86	94.76	94.22	90.26	90.65
\$150,000	99.07	99.42	99.33	98.90	98.70	97.81	97.44	95.58	95.54	94.99	92.16	92.30
\$200,000	99.17	99.61	99.63	99.24	99.04	98.50	98.13	96.33	96.32	95.65	93.47	93.81
\$300,000	99.79	100.00	99.78	99.66	99.31	98.94	98.82	97.47	97.36	97.00	95.63	96.15

SOURCE: Florida Department of Insurance Medical Malpractice Closed Claims Data Set.

previously presented analysis indicates considerable geographical variations in claims frequency. Because of the low number of claims in smaller counties, which would allow a handful of extremely large claim payments to distort comparisons, this analysis includes only results for counties with a population in excess of 250,000. Among these Florida counties, the highest mean severity for claims was reported in Palm Beach County, which showed a twelve-year average of \$117,236; the lowest mean severity was reported in Sarasota County, which had a twelve-year average of \$47,185.

Table 23 compares average claim severity for the south Florida urban counties (Dade and Broward) with that for the rest of the state. The average claim size in these two urban counties was 18.6% higher than the rest of the state for the twelve-year period and 42.4% higher during the three most recent years, 1984 through 1986.

4. The Relative Impact of Increased Frequency and Increased Severity on Total Loss Payments

In summary, both of the factors that determine total claims costs—frequency and severity of claims—have been responsible for the large increase in total paid claims and the resulting increase in malpractice premiums in Florida. The rate of increase in average cost per paid claim, however, substantially exceeds the growth in frequency. Stated differently, more generous verdicts and higher insurance company settlements have contributed more to Florida's increased medical malpractice loss payments than has increased litigiousness or increased claims consciousness on the part of Florida's population.

C. PHYSICIANS WITH MULTIPLE CLAIMS

As suggested in the introduction, some attorneys have claimed that the medical malpractice crisis is primarily the fault of increased medical negligence or "bad doctors."⁸⁸ No attempt was made in this study to have each case examined by independent medical experts to determine whether there was "actual negligence." Rather, the closed claims data were analyzed to determine what portion of claims payments resulted from cases against physicians with multiple paid claims. A high concentration of paid claims among physicians with multiple paid claims may indicate that such doctors were not sufficiently skillful or careful. On the other hand, in many cases multiple paid claims undoubtedly result from other factors. For example, multiple claims may occur because a physician is practicing in a high-risk

⁸⁸ See *supra* note 16 (listing articles describing views of trial lawyers).

TABLE 23
MEAN SEVERITY OF MEDICAL MALPRACTICE PAID CLAIMS IN FLORIDA: DADE/BROWARD COMPARED TO THE REST OF THE STATES: 1975-1986

Territory	Mean	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
Dade/Broward	\$88,190	\$25,494	\$27,492	\$29,379	\$47,086	\$55,552	\$67,318	\$79,905	\$137,072	\$117,566	\$169,045	\$142,256	\$160,122
All of Florida	80,454	26,540	25,991	34,985	41,193	54,361	80,556	74,592	123,700	114,105	144,015	126,334	121,073
Rest of the state	74,387	27,278	21,662	38,424	36,064	53,556	90,063	70,491	112,851	111,153	119,645	116,094	94,525

SOURCE: Florida Department of Insurance Medical Malpractice Closed Claims Data Set
NOTE: Figures are unadjusted for inflation. Years refer to the calendar year of closing.

specially or a high risk area of the state. In addition, some physicians may be more frequently willing to treat high-risk patients for which unfavorable results are to be expected. Even a random distribution of claims among Florida physicians would result in some number of physicians with multiple paid claims.

The Florida closed claims data show that of the approximately one-half billion dollars paid to claimants during the period 1975 to 1986, almost one-half was accounted for by physicians with two or more paid claims.⁸⁹ Table 24 portrays the number of physicians against whom one or more of paid claims were made. Column (1) displays the number of claims involved. Column (2) shows that a total of 3,229 physicians experienced one indemnity claim each; this number accounted for 78.8% of the number of paid claims. The sum of \$296.7 million was paid to resolve these claims, and this amount represented 57.8% of the total amount paid during the period. The balance of the table is read in a similar fashion.

During the period 1975 through 1986, 867 Florida physicians had two or more paid claims — approximately 4% of all physicians. This group was responsible for \$216.9 million dollars in paid claims, which is 42.2% of the total claims payments. Figure 9 illustrates the portion of total claims payments that results from claims against physicians with one paid claim, with two paid claims, with three paid claims, and with more than three paid claims.

The number of physicians with multiple paid claims also was broken down by specialty. There were more general practitioners among the total number of physicians who had one claim against them, nearly 14% more than for any other specialty. This likely results from general practice being the most common specialty.⁹⁰ Among physicians with two or more claims, the largest group was obstetricians and gynecologists. Other specialties with high concentrations of physicians with multiple claims included orthopedics, general surgery, and general practice. The non-random distribution of physicians with multiple claims suggests that, in some cases, physicians with multiple

89 An investigation into the number of claims experienced by each physician from 1975 through 1986 was accomplished by merging the closed claims data file with a list containing the names of physicians practicing in the state. The name of each physician in the approximately 21,000 closed claims was examined to determine how many claims were closed for each physician during the 12-year period or any portion thereof.

90 As shown in table 17, *supra*, the number of paid claims per 100 physicians is less for general practitioners than for the average of all physicians. General practitioners rank seventh of the eight specialties listed in table 17 in terms of frequency of claims per physician.

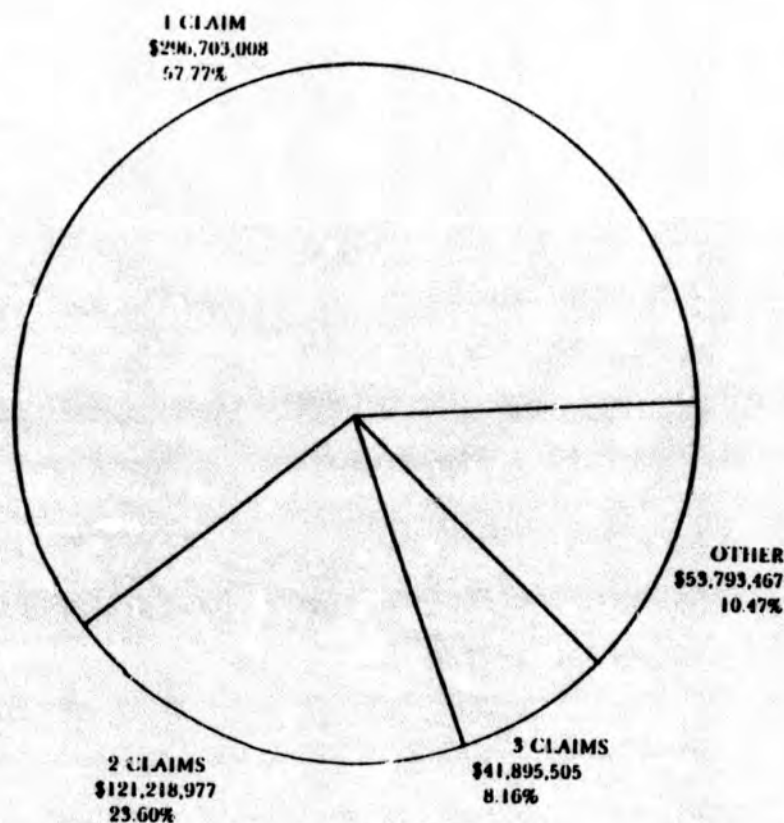
TABLE 24

MULTIPLE CLAIM ANALYSIS OF MEDICAL MALPRACTICE CLOSED CLAIMS IN FLORIDA: 1975-1986

Number of Non-Zero Claims per Physician/ Surgeon	Number of Physicians	Number of Claims	Percent of Claims	Cumulative % of Claims	Total Indemnity Amount	Percent of Indemnity	Cumulative % of Indemnity
Frequency							
1	3,229	3,229	78.8330	78.8330	\$296,703,008	57.7680	57.7680
2	588	1,176	14.3535	93.1865	121,215,977	23.6013	81.3694
3	164	402	4.0035	97.1904	41,893,503	8.1571	89.5264
4	53	212	1.2039	98.4863	10,009,391	3.7011	93.2275
5	38	190	0.9277	99.4141	17,519,203	3.4110	96.6385
6	12	72	0.2930	99.7070	5,333,256	1.0364	97.6769
7	9	21	0.0732	99.7803	5,147,320	1.0022	98.6791
8	2	10	0.0466	99.8291	1,517,650	0.2933	98.9746
9	3	27	0.0732	99.9023	3,326,868	0.6481	99.6228
10	1	10	0.0244	99.9268	173,000	0.0341	99.6568
11	1	11	0.0244	99.9512	313,701	0.0613	99.7183
12	1	13	0.0244	99.9756	379,835	0.0740	99.7923
13	1	34	0.0244	100.0000	1,066,983	0.2077	100.0000
Totals	4,096	5,503			\$513,610,937		

SOURCE: Florida Department of Insurance Medical Malpractice Closed Claims Data Set

FIGURE 9
MEDICAL MALPRACTICE PAID CLAIMS IN FLORIDA ACCORDING TO THE
NUMBER OF PAID CLAIMS PER PHYSICIAN: 1975-1986



SOURCE: Table 35

NOTE: Figures are not adjusted for inflation.

claims are not necessarily "bad doctors," but merely practice in high-risk specialties or perform high-risk procedures.

That over 40% of all claims payments is attributable to 4% of physicians, however, does suggest that significant potential exists for reducing paid claims by controlling the losses generated by physicians with multiple claims. The substantial dollar amount of payments attributable to physicians with multiple paid claims raises the question of what methods currently are in place to review or regulate the quality of medical care practiced by such physicians. Two types of external discipline are possible. One is a market-based incentive that would surcharge physicians who generate excessive amounts of claims. The other, not market based, is professional regulation such as that provided by state licensing boards, professional medical societies, or hospital staff regulation. Either alternative likely would provide substantial additional incentives to ensure quality medical care.

V. CONCLUSION

The study of Florida closed claims in this article presents a comprehensive picture of the expanding costs imposed by medical malpractice. While not addressing the equity of a claims payment in any single case, this study shows that the costs of medical malpractice coverage are exacting an increasingly burdensome toll on physicians, particularly those in high-risk specialties such as obstetrics and neurosurgery. This study demonstrates that increased premiums are not the result of high insurance company profits but rather are primarily driven by increased loss payments. Insurance industry rating and pricing practices and fierce premium competition within the industry have exacerbated the effect of recent premium increases. When viewed over the course of a decade, however, the dramatic increase in claims payments is the dominant cause of increased malpractice premiums.

Also, perhaps surprisingly, the frequency of claims payments is not primarily responsible for increased claims costs. Physicians in Florida have about the same chance of having a claim filed against them today as they did in 1975. Rather, the huge increase in the size of claims payments, particularly the increasing frequency of very large payments, largely accounts for the total increase in paid losses. Presumably, those larger claim payments resulting from settlement reflect the beliefs of defense attorneys and malpractice insurance claims managers that, if such claims proceeded to trial, the ultimate judgments would be higher than they were in 1975. This belief may derive from more serious iatrogenic injuries, a concern that juries are more likely to award larger verdicts and that judges are less likely to control them, a sense that the plaintiffs' trial bar is more able than

before, or a concern that the insurer will be held liable under a bad faith claim if it fails to settle within policy limits.⁹¹

When physicians complain about dramatically increased premiums, the temptation exists to assume that the way things were a decade ago was the norm or the way things should be. On the other hand, a societal choice may be made that the detriments of increased medical costs, and in some cases reduced physician income, are warranted by the need to compensate injured plaintiffs and to preserve the full array of rights that plaintiffs currently enjoy in the tort system. If the contrary decision is made, however, the results of this study suggest that substantial tort reform aimed at reducing the size of verdicts and settlements probably will be required. At the same time, increased professional regulation of physicians and insurance reform designed to reduce the premium differential between high-risk and low-risk physicians should not be viewed as mutually exclusive alternatives to tort reform but instead, as complementary ingredients of a comprehensive and effective package of medical malpractice solutions.

91. See generally *Crisco v. Security Ins. Co.*, 66 Cal. 2d 425, 431, 426 P.2d 173, 176-77, 58 Cal. Rptr. 13, 17 (1967) (failure of insurer to settle within policy limits sufficient evidence of breach of duty to consider insured's interest); *Rova Farms Resort, Inc. v. Investors Ins. Co. of Am.*, 65 N.J. 474, 496, 323 A.2d 495, 507 (1974) (failure of insurer to settle within policy limits when policy restricts insured's rights to settle is breach of fiduciary duty to negotiate settlement within policy limits if possible); *Levantino v. Insurance Co. of N. Am.*, 102 Misc. 2d 77, 87-88, 422 N.Y.S. 2d 995, 1003 (Sup. Ct. 1979) (failure of insurer to settle within policy limits evidence of bad faith giving rise to action in tort); *Fla. Stat. § 624.155* (1985) (creating cause of action for insured against insurer for failure to make good faith attempt to settle claim).

DEATH FROM AUTOEROTIC ASPHYXIATION AND THE DOUBLE INDEMNITY CLAUSE IN LIFE INSURANCE POLICIES: THE LATEST ROUND IN ACCIDENTAL DEATH LITIGATION

Francis Achampong*

INTRODUCTION

Apart from the traditional death benefit payable under life insurance policies, there may be added benefits such as the accidental death benefit, waiver of premium for disability, and the guaranteed insurability rider.

On the application of the insured, and for an additional premium, the accidental death benefit may be added to the basic death benefit in a life insurance policy, if the insured meets the particular insurer's underwriting requirements for the coverage.¹ The accidental death benefit is provided in an amount equal to the policy face², hence the reference to "double indemnity" in the context of the accidental death benefit.

Policies containing an accidental death benefit may employ different terminology in according the coverage. Some courts have recognized two types of clauses—"accidental means" clauses on the one hand, and "accidental death" or "accidental result" clauses, on the other.³

*I.L.B. (Ghana), I.L.M. Ph.D. (Univ. of London), I.L.M. (Georgetown), member of the New York Bar, Associate Professor of Business Law and Insurance, Norfolk State University, Norfolk, Virginia.

1. It is an integral part of some life insurance policies. Accident and health insurance policies may also insure against accidental death.

2. Thus, in a policy with a \$100,000 limit, the accidental death benefit would be \$100,000, resulting in a \$200,000 recovery for accidental death within the coverage of the policy.

3. See, GREIDER, CRAWFORD AND BEADLES, *LAW AND THE LIFE INSURANCE CONTRACT* 210 (1984); also, APPLEMAN, *INSURANCE LAW AND PRACTICE* 360 (1981) (where he refers to the "accidental means" provision as "that simple, yet tricky, little term"). This distinction was recognized in cases such as *National Life and Accident Ins. Co. v. Knapp*, 430 S.W.2d 84, 88 (Tex. Civ. App. 1968); *Braley v. American Home Assurance Co.*, 354 So. 2d 904, 906 (Fla. Dist. Ct. App. 1978); *McKinnon v. Republic National Life Ins. Co.*, 25 Wash. App. 854, 862, 610 P.2d 944, 948 (1980) (Reed, C.J., concurring). The actual wording of either type of clause has many variations. For a sample of each, see GREIDER, CRAWFORD AND BEADLES, at 210-211.

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**NEW IDEAS FROM CONCERNED ORGANIZATIONS:
THE PIAA PROPOSAL:
ESTABLISHMENT OF FAULT
BY EITHER ADMINISTRATIVE REVIEW
OR NORMAL ADJUDICATION
FOLLOWED BY INDEMNIFICATION
USING A FIXED BENEFIT PROGRAM**

Current Situation

Currently, medical professional liability claims are covered by the tort system. Although most claims are settled without a trial, such settlements are framed to reflect recent results of similar cases which were tried to conclusion. The likelihood and level of a payment is often not necessarily related to reasonable indemnification to the injured party. Rather, payments reflect a lottery type result characterized by a few big winners and many losers. It is sometimes suggested that a fixed benefit system, like workers' compensation, might be the solution to the excessive costs of medical professional liability. Early assessments of such an approach raise significant concerns that it might be tied to a "no-fault" determination of recipients. This could produce major cost increases rather than savings as all patients with an incomplete cure would be left with some form of economic or emotional loss. Any viable proposal incorporating fixed benefits schedules also should retain a method of establishing fault.

Rationale for the Change

In theory, the tort system intends that the tortfeasor (the individual committing the *negligent act*) *indemnify* the injured party. In the area of medical professional liability, most will agree that the determination of "negligent act" has become blurred. As importantly, the concept of "indemnification" has also become blurred. Large awards to a few people and no, or very small, awards to many does not seem consistent with the concept of indemnification. Further, the cost of participating in the tort system (e.g., all legal expenses - both plaintiff and defendant) easily adds 50% + to the costs of "indemnifying" injured parties via this system.

Therefore, in order to reduce the inefficiencies (in the cost of utilizing the system) and improve the effectiveness (who receives indemnity and how much) of the tort system, it is suggested that a scheduled benefit system be implemented. A program which specifies the

noneconomic value of certain injuries while assuring payment for valid medical costs and other warranted financial loss is certain to speed up the entire reparations mechanism. Under current methods, disagreement over damage values becomes only the stumbling-block in the path of just compensation. The public good is best served when prompt, fair indemnification replaces uncertainty. As implied above, all proposals fostering such change must contain two major elements - a satisfactory method of determining fault and a responsive yet economically feasible indemnification concept.

Fault Determination

A number of proposals which incorporate fixed benefit schedules suggest some administrative method in establishing qualification for payment. Such an approach would serve to reduce the emphasis on emotional issues now found in the court process and hopefully would inject a more rational analysis of fact in deciding who shall recover. It is also expected that this method would produce economies over the present system through streamlined proceedings. Prospects of such savings, if any, will be dependent upon the administrative structure selected and the decision as to who is responsible for those costs.

The biggest issue raised in opposition to the concept of administrative determination of fault is the insistence that everyone has a constitutional right to a trial. There is precedent for an administrative approach to determining fault in workers' compensation where review is used to determine whether or not questionable injuries qualify. Rather than have the entire proposal stand or fall on this one issue, we recommend that the method of fault determination be optional with the administrative method preferred but a trial on the issue of negligence alone available to those who insist upon it.

Benefit Schedules

A cornerstone of any proposal seeking to alter the present system dramatically should aim at consistency in paying for compensable loss. A schedule of benefits fixing value on each type of injury seems the best way to accomplish this. The workers' compensation experience indicates just how difficult it is to complete the task. Significant variations within general injury classifications and marked variances in base values state to state have hampered such attempts, but the framework does exist for extension to a medical liability application. While

specific conclusions as to dollar amounts will vary, we believe four fundamentals should be incorporated:

1. All medical payments associated with the injury should be reimbursed - as incurred and not otherwise provided.
2. Lost wages should be capped at a reasonable level - paid as incurred and not otherwise provided.
3. Payments should include an element of pain and suffering compensation for permanent or temporary total impairment.
4. Attorney fees should be better associated with actual work performed (including some compensation for work done in a losing effort).

Some may argue that medical payments should have an aggregate limitation and that noneconomic loss payment should be eliminated. We contend, however, that these elements must be included as a trade-off for other limitations imposed. In addition, retention of these features is essential in order to maintain that all fundamental financial loss is compensated.

If this concept is adopted as desirable by the PIAA, then there are a number of issues to be resolved such as the following:

- Limitation on wage payment levels. {These are best tied to state averages.}
- Benefits to survivors, unemployed injured persons, etc.
- Adjudication of disputes over reasonableness of medical costs.
- A more specific permanent impairment schedule.
- The level of payments in cases where the plaintiff's award would be reduced by comparative negligence.
- The use of lump sum settlements in the context of a fixed benefit system.

In some cases, these issues should be addressed by considering appropriate state workers' compensations laws. There are other proposals which compare to this one such as those from Kansas (The Midwest Institute for Health Care and Law) and the combined AMA/CMSS effort. Our comments on those concepts indicate those concerns which we conclude must be addressed and the direction which we would take if we were to proceed further with this concept of our own.

Ideally, the changed system will provide more economic security to injured parties as well as allow the defendants to better predict (but not necessarily reduce each time) the cost of doing business.

Modification to Current Law

1. Create an administrative body to determine negligence on a final and binding basis as an alternative to the current trial process.

The "administrative body" established as an alternative to the jury system would be an independent (neutral) body charged with the determination of negligence. Patients (or their beneficiaries) would have direct access to the administrators. The "administrative body" would be staffed with experts in the area of health care delivery and well qualified to make determinations of negligence. The administrative body would have all powers of investigation including:

- subpoena of records,
- deposition of witnesses, and
- retention of expert witnesses.

The optimal structure of this administrative body, in our view, would be a three-person panel consisting of a judge, a physician, and a member of the public. This group makeup would be similar to the pretrial screening panels used in several states. The concept of a three-doctor panel was seriously considered and rejected. Such an approach could bring many accusations of a self-serving process while a mixed group of impartial reviewers will do just as well, so long as the rules are set properly. Such rules should be set by a commission responsible for the entire process.

If there is great objection to the use of a judge, a doctor, and a public member, alternative groups could be considered. In each case medicine should be represented, as the technical issues must be included in any deliberation. If a three-member panel is unacceptable to those considering this general reform, an administrative law judge or magistrate would be our next preference.

Additional specifics would include the provision that the reviewing body can consolidate other parties into the action. Full discovery must be allowed and expert testimony limited to similarly situated physicians. Each party has the right to submit expert opinions from physicians in the same specialty. Entry to the system could be gained with or without a lawyer. The plan calls for supplemental payment of the lawyers' fees, but there is still some financial risk for the plaintiff with a marginal case.

As suggested earlier, parties alleging injury due to medical negligence would have the advance option of using the current (tort) system; however, in *all* cases where an injury is determined to be a result

of negligence, the schedule of benefits would apply. In the event that there are multiple plaintiffs and any one of them opts for the current trial process in determining negligence, the case will be handled in the courts.

The optional approach to the establishment of fault is an important feature. Suggestions mandating administrative or arbitration avenues as the sole remedy for patients believing themselves the victims of malpractice may fail the question of whether or not they discriminate. Juries are not always the best at establishing fault, but the general view is that they tend to perform this function far better than the setting of damage values. The risk of a successful constitutional challenge of this proposal is far greater without this option, and the trade-off in using it may not be significant.

2. Establish a schedule of benefits applicable to all cases where negligence is determined.

To this point, the proposal resembles a form of optional arbitration. In awarding compensation, however, it is very different. Once fault is found by either court or panel, payment must be made through a schedule of benefits. The schedule of benefits would be established with one underlying goal — fair, quick and uniform compensation of parties injured due to negligence. Medical costs, including costs of rehabilitation, limited wage loss, and other related losses would be provided for on a continuing basis similar to workers' compensation. This would include unlimited medical benefits, and wage loss recovery as a function of actual lost wages. All benefits would be paid as incurred. The limit on lost wages, after reduction for payments from alternate sources of compensation, would include a specified reduction to offset reduced taxes and a cap equal to a reasonable multiple of the prevailing average wage.

In addition, a schedule of benefits would be established for noneconomic losses, guarantying uniform and equitable treatment of this subjective component of loss. Of the methods now in use in workers' compensation, the method which seems most equitable establishes a set amount for permanent total disability and then identifies percentages of that total that are appropriate for each type of partial loss. In this manner, cost of living changes can be incorporated by a simple adjustment of the base. A further variable for the age of the patient should also be included by setting percentage reductions in the noneconomic loss payments at differing age increments.

It is expected that legal costs for a winning plaintiff must be paid

in addition to these specified benefits. This too parallels some aspects of the workers' compensation mechanism. Such payments must be geared to an acceptable rate for actual hours expended. Also, since this proposal reduces the usually higher contingency payments and their ability to reimburse expenses of losing efforts, we propose some compensation in those cases as well. We suggest payment for 33-1/3% of actual hours, provided the tribunal concludes that there was due cause for the action. This can be determined early in the process. Such a feature, although unpopular with those on the defense side, seems the most equitable solution in attempting to maximize the compensation of those injured through negligence without adding to the costs passed on to health care providers.

Impact on Future Costs

While some immediate savings could be gained from a carefully designed payment schedule and administrative structures, the bigger benefits will come from a true moderation in the rate of increase in average loss cost and the assurance that more of the malpractice premium dollar will reach the injured parties. The system is likely to produce a greater number of compensated cases (much like the results of arbitration to-date) while at the same time it generates savings by streamlining the process of recovery.

The committee endorses proposals for change which incorporate the key features described herein.

C.7

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August 5, 1988

Mary A. Pierce
Executive Director
Medical Indemnity Corporation of Alaska
4000 Old Seward Highway, Suite 203
Anchorage, Alaska 99503

Re: Effective Tort Reform Legislation

Dear Ms. Pierce:

You, like many other executive officers of medical societies and physician sponsored insurers, are likely involved in continuing efforts to obtain passage of effective tort reform.

At the May 1988 Physician Insurers' Association of America Annual Meeting I had the opportunity to discuss the importance of the "fine print" in tort reform legislation. So many people in the audience requested copies of my slides that I prepared the attached annotated version of those slides.

The information on pages two through four can be used as a checklist in reviewing tort reforms you may be considering. Actuarial techniques can be used to evaluate how much "fine print" in the tort reform language might affect the value of the reforms.

If you have any questions about this material, or if I can be of any other assistance to you, please feel free to call me or my associate, Spencer Gluck.

Very truly yours,

Allan Kaufman -sc.
RECEIVED
Allan Kaufman, F.C.A.S.
AUG 15 1988

AK/pr
cc: D. Bickerstaff

MICA

How Effective is Tort Reform?

Read the Fine Print

Tort reform can work.

The largest "laboratory" to date has been the medical professional liability system in California. Here, a package of tort reforms including many of the currently popular elements was passed following the mid-seventies medical malpractice insurance crisis. At that time, California joined New York and Florida among the national leaders in medical liability costs. Today, California's medical liability costs are far closer to the national average.

Patricia Danzon, currently at University of Pennsylvania, compared medical liability costs from 1975 to 1984 in a number of states with and without tort reforms, calculating these average savings associated with various types of tort reforms:

Caps on non-economic loss	23%
Collateral sources offsets	11-18%
Contingency fees limitations	3%
Reduced statute of limitations	8% per year
Structured settlements	Not tested
Joint & Several Liability	Not tested

Of course, these estimates of savings are in comparison to what costs otherwise would have been, and represent average results for the states studied.

Remember, successful tort reform means that costs are lower than they otherwise would have been. It is unlikely that tort reform will produce costs below the starting point for an extended period.

Tort reform can also fail.

Or be relatively ineffective. Or be less effective than it might have been. For each of the types of reform listed above, there have been a number of variations in bills which have passed, and even more in bills which have been considered. Small differences in wording can have profound implications, some of which may be unintended. To evaluate an existing or proposed tort reform, be sure to read the "fine print".

We've worked on many variations of tort reforms in proposals, bills, and laws in a number of states. The following list illustrates some of the possible variations and important factors which affect the value of those reforms. The list begins with a ball-park estimate of the savings which the reforms might produce for medical professional liability.

Limitations on Non-Economic Loss

Estimated savings can range from zero to fifty percent, depending on:

1. Amount of Limitation. Proposals range from complete elimination to a \$1,000,000 limitation.
2. Per Incident or Per Claimant. This distinction is significant, but without proper attention the wording of the law may not even be clear.
3. Flat or Graded. Flat limitations are more common. Graded limitations usually apply the maximum to only the most serious cases and then grade the limitation down for less serious cases (e.g. in proportion to "capacity to enjoy life").
4. Definition of Non-Economic Loss. For example, future wage loss in one jurisdiction is considered speculative and therefore non-economic.
5. Variation by Claimant Characteristic. For example, the limitation may vary by age of claimant and/or degree of injury.
6. Indexation of the Limitation for Inflation.

Collateral Source Offsets

We've estimated savings in this area from zero to fifteen percent.

1. Mandatory or Judgmental Offset. Possible wordings include: "evidence may be introduced"; "judge/jury may consider"; or "judge/jury shall reduce".
2. Offset by Judge or Jury. There's opinion (although no evidence) that offset by the judge produces greater savings.
3. Exceptions to Offset. Possibilities include medicare, life insurance, public insurance, insurance paid by claimant, insurance with subrogation provisions, insurance paid by employer.

4. Past Damages Only or Past and Future Damages. The language of a number of current laws appears to apply to past damages only, whether or not this was intended when the law was written.
5. Offset for Premium Paid by Claimant.

Contingency Fee Limitations

Estimated savings range from zero to ten percent.

1. Selected Schedule. Most limitations take the form of some kind of schedule. That schedule may include percentages higher than current prevailing fees.
2. Schedule Variations. Most schedules vary the percentage by size of award. Others may also vary the percentage by case disposition (i.e., claim, suit, trial, appeal).
3. Treatment of expenses. Are trial, court and expert fees counted as part of the schedule or in addition to the schedule fee? Alternatively, is the award/settlement reduced by expenses before the fee is applied?

Statute of Limitations

We've estimated savings ranging from zero to fifteen percent.

1. Cutoff Period. We've seen anywhere from two years to ten years.
2. Cutoff by Occurrence Date or Discovery Date. Another possibility is both, e.g. "four years from incident or two from discovery, whichever is later".
3. Definition of Discovery Date. "Did discover" or "could have discovered" or "should have discovered" etc.
4. Statute of Repose or Statute of Limitations. A statute of repose operates more restrictively. The courts may decide which it is; careful wording in the law can cause it to operate as a statute of repose.
5. Exceptions. The potential list includes infants, foreign objects, continuing treatment, drugs or radiation, and concealment or fraud.

Periodic or Structured Settlements

Estimated savings range from zero to ten percent.

1. Optional or Mandatory.
2. Size Requirements. For example, "awards over \$250,000" or "awards with future damages over \$100,000".
3. Applied to Economic Loss, Non-Economic Loss, or both.
4. Treatment of Inflation. Examples include inflation calculated at the jury's discretion, at a fixed rate specified by statute, or at a fixed relationship with a stated index.
5. Court Rules on Treatment of Inflation and Interest. This item refers to conditions before the change in law. Previous assumptions regarding inflation and interest may have been specified in statute or in case law. In other instances it may be difficult to determine prevailing assumptions.
6. Payment Periods. Possibilities include a specified payment period (e.g., 10 years), a specified maximum payment period, payment for life expectancy.
7. Payments May or May Not Terminate at Death. Frequently, some payments terminate (e.g., medical costs) while others may not (e.g., wage loss).
8. Financial Guarantees Required. For example, insurer with specified Best's rating.
9. Treatment of Attorney's Fees. In some instances, attorney's fees may be completely exempted from periodic payments. Other possibilities include lump-sum payments with required present value calculations or separate rules for scheduled payments.

Joint and Several Liability

We haven't estimated significant savings to doctors in this area.

1. Economic Versus Non-Economic Losses. A number of existing versions abolish joint and several liability for non-economic losses only.
2. Proportionate Liability in All Cases or Only Below A Threshold. For example, some laws establish proportionate liability for those under 50% liable, but provide that all damages may be assessed against those over 50% liable.

3. Among Whom are Damages Apportioned. For example, in a case involving a work-related injury, may the employer be included?

* * * *

Summary and Conclusion

There is evidence that tort reform can be an effective means for reducing the growth in liability costs. Still, simply passing a tort reform bill by no means ensures that savings will be realized. It is no accident that we included zero in each possible range of results. Some versions of tort reform may even increase costs. The fine print of the law, the court instructions used to implement the law, and court interpretations of the law will all act to determine the effectiveness of a tort reform measure. An important first step is to read the fine print.

STUDY: TORT REFORM "ONLY IDENTIFIABLE FACTOR" IN LOWER RATES

A study of mature claims-made premiums charged by 46 physician-owned professional liability companies, released late in 1987, reveals that premiums charged by all four of the MD-owned carriers in the state are substantially lower than those in other populous states, and lower than some less populous states.

"This data provides further concrete evidence that California's tort reform measures are working," says Ron Neupauer, underwriting manager for Medical Insurance Exchange of California, which conducted the study.

"California is unique among populous states because of MICRA (Medical Injury Compensation Reform Act)," Neupauer said.

Quality of care and practice patterns are not different in this state and the legal climate and liberal appellate court decisions all would tend to drive up professional liability claims costs and premiums as they have in other states, Neupauer said.

"MICRA appears to be the one identifiable California only factor which has contributed to its lower rates," he theorized.

Neupauer said that 12 years ago, California's premiums were among the highest. Now the differences are dramatic.

"An obstetrician would pay as much as \$152,881 in Miami, compared to \$45,868 in Los Angeles. Obstetricians' rates in Michigan, Maryland

INTERNAL MEDICINE

	A	B
1	MICH (MPMLC)	\$19,279
2	NEW YORK	\$18,533
3	FLORIDA (FPIC)	\$17,402
4	FLORIDA (FPIT)	\$14,770
5	FLORIDA (PPTF)	\$14,663
6	ALASKA (MICA)	\$12,030
7	MARYLAND	\$11,725
8	ALASKA (MIEC)	\$11,256
9	MICH (PICOM)	\$10,223
10	NEVADA	\$9,480
11	ILLINOIS	\$9,020
12	ARIZONA	\$8,248
13	MISSOURI (MMIC)	\$7,932
14	HAWAII	\$7,629
15	NEW JERSEY	\$7,436
16	PENNSYLVANIA	\$7,234
17	WYOMING	\$6,156
18	OHIO (PICO)	\$5,909
19	CALIF (MIEC)	\$5,908
20	GEORGIA	\$5,898
21	CALIF (DOCTORS)	\$5,896
22	CALIF (SCPIE)	\$5,864
23	MONTANA	\$5,788
24	MISSOURI (MDA)	\$5,522
25	MAINE	\$5,414
26	CALIF (NORCAL)	\$5,412
27	DIST COLUMBIA	\$5,365
28	TENNESSEE	\$5,340
29	TEXAS (TMLT)	\$5,256
30	CONNECTICUT	\$5,254
31	OREGON (NPMIC)	\$4,951
32	WASHINGTON	\$4,756
33	IDAHO	\$4,740
34	WISCONSIN	\$4,189
35	KENTUCKY	\$4,156
36	ALABAMA	\$4,124
37	LOUISIANA	\$4,032
38	IOWA	\$3,700
39	COLORADO	\$3,660
40	NORTH CAROLINA	\$3,427
41	MINNESOTA	\$3,181
42	NEW MEXICO	\$3,104
43	UTAH	\$3,071
44	MISSISSIPPI	\$2,659
45	OKLAHOMA	\$1,751
46	INDIANA 100/300	\$1,356

OBSTETRICS/GYNECOLOGY

	E	F
1	FLORIDA (FPIC)	\$152,881
2	FLORIDA (FPIT)	\$137,399
3	FLORIDA (PPTF)	\$134,496
4	MICH (MPMLC)	\$124,635
5	MARYLAND	\$99,244
6	NEW YORK	\$94,113
7	ALASKA (MIEC)	\$76,536
8	MISSOURI (MMIC)	\$67,419
9	MICH (PICOM)	\$66,412
10	NEVADA	\$64,448
11	ALASKA (MICA)	\$64,253
12	ARIZONA	\$57,068
13	MISSOURI (MDA)	\$55,804
14	HAWAII	\$51,360
15	TEXAS (TMLT)	\$50,278
16	DIST COLUMBIA	\$43,280
17	PENNSYLVANIA	\$46,196
18	CONNECTICUT	\$47,521
19	GEORGIA	\$46,791
20	ILLINOIS	\$46,648
21	CALIF (SCPIE)	\$45,868
22	COLORADO	\$42,644
23	WYOMING	\$42,172
24	OREGON (NPMIC)	\$41,062
25	OHIO (PICO)	\$40,377
26	CALIF (DOCTOR)	\$40,368
27	IDAHO	\$40,260
28	CALIF (MIEC)	\$40,156
29	CALIF (NORCAL)	\$40,136
30	MAINE	\$40,115
31	MONTANA	\$39,660
32	ALABAMA	\$37,267
33	WASHINGTON	\$36,329
34	KENTUCKY	\$34,117
35	UTAH	\$32,938
36	IOWA	\$31,828
37	NEW JERSEY	\$31,476
38	WISCONSIN	\$31,412
39	LOUISIANA	\$29,235
40	NORTH CAROLINA	\$28,626
41	MISSISSIPPI	\$22,788
42	TENNESSEE	\$20,992
43	MINNESOTA	\$18,640
44	NEW MEXICO	\$16,153
45	INDIANA 100/300	\$11,526
46	OKLAHOMA	\$11,393

GENERAL SURGERY

	C	D
1	FLORIDA (FPIC)	\$91,730
2	FLORIDA (PPTF)	\$80,698
3	MICH (MPMLC)	\$73,961
4	FLORIDA (FPIT)	\$68,538
5	MARYLAND	\$55,621
6	NEW YORK	\$55,295
7	MISSOURI (MM)	\$51,557
8	PENNSYLVANIA	\$45,635
* 9	ALASKA (MIEC)	\$40,520
10	MICH (PICOM)	\$39,549
* 11	ALASKA (MICA)	\$37,565
12	MISSOURI (MD)	\$34,601
13	ARIZONA	\$34,272
14	NEVADA	\$34,120
15	OHIO (PICO)	\$33,327
16	CALIF (SCPIE)	\$33,024
17	ILLINOIS	\$31,256
18	CONNECTICUT	\$29,700
19	KENTUCKY	\$28,494
20	TEXAS (TMLT)	\$28,360
21	GEORGIA	\$28,308
22	HAWAII	\$27,453
23	MAINE	\$27,059
24	DIST COLUMBIA	\$26,823
25	OREGON (NPMI)	\$26,504
26	NEW JERSEY	\$25,208
27	COLORADO	\$24,356
28	CALIF (NORCAL)	\$24,024
29	WASHINGTON	\$23,360
30	WYOMING	\$22,360
31	CALIF (DOCTOR)	\$21,380
32	MONTANA	\$21,500
* 33	CALIF (MIEC)	\$21,250
34	LOUISIANA	\$21,185
35	ALABAMA	\$20,934
36	IOWA	\$19,908
37	UTAH	\$19,735
38	WISCONSIN	\$18,951
39	IDAHO	\$17,052
40	MINNESOTA	\$15,609
41	MISSISSIPPI	\$15,192
42	NORTH CAROLINA	\$15,182
43	TENNESSEE	\$15,096
44	NEW MEXICO	\$12,534
45	OKLAHOMA	\$8,702
46	INDIANA 100/3	\$7,119

NEUROSURGERY

	G	H
1	FLORIDA (PPTF)	\$170,363
2	MICH (MPMLC)	\$159,190
3	FLORIDA (FPIC)	\$152,881
4	FLORIDA (FPIT)	\$137,399
5	NEW YORK	\$115,240
6	MARYLAND	\$100,118
* 7	ALASKA (MICA)	\$89,809
* 8	ALASKA (MIEC)	\$76,536
9	MICH (PICOM)	\$73,128
10	MISSOURI (MMIC)	\$71,390
11	PENNSYLVANIA	\$69,877
12	NEVADA	\$64,448
13	ILLINOIS	\$63,752
14	ARIZONA	\$59,744
15	GEORGIA	\$58,855
16	MISSOURI (MD)	\$55,804
17	OHIO (PICO)	\$53,835
18	TEXAS (TMLT)	\$53,303
19	DIST COLUMBIA	\$52,903
20	HAWAII	\$51,860
21	KENTUCKY	\$48,577
22	MAINE	\$47,948
23	CONNECTICUT	\$47,521
24	LOUISIANA	\$46,606
25	OREGON (NPMIC)	\$44,540
26	CALIF (NORCAL)	\$43,976
27	UTAH	\$43,862
28	NEW JERSEY	\$41,698
29	CALIF (MIEC)	\$40,156
30	WYOMING	\$39,972
31	IOWA	\$39,820
32	WISCONSIN	\$39,796
33	CALIF (SCPIE)	\$38,964
34	COLORADO	\$38,584
35	CALIF (DOCTORS)	\$38,260
36	WASHINGTON	\$38,150
37	MONTANA	\$37,596
38	ALABAMA	\$37,267
39	IDAHO	\$32,208
40	NORTH CAROLINA	\$31,515
41	MISSISSIPPI	\$30,388
42	TENNESSEE	\$22,511
43	MINNESOTA	\$19,470
44	NEW MEXICO	\$16,158
45	INDIANA 100/300	\$11,526
46	OKLAHOMA	\$11,393

and New York also are at or over the \$100,000 threshold," he said.

Subsequent success in California in enacting and upholding such tort reforms as caps on non-economic damages, limits on contingent fees, periodic payment of future damages, and collateral source rule changes all have contributed to the moderation of doctors' premiums. This should provide sound support for similar reforms in other states, Neupauer suggested.

In looking at the data collected, Neupauer pointed out that in some states, rates would be higher but for the intervention of state regulatory agencies, which in some cases may imperil certain companies' solvency.

"Claims that these insurance companies are 'profiteering' or overcharging are insupportable," he concluded.

NEXT MONTH: A report on proposed rates sought by some commercial carriers. Also, an update on tort reform and a surprising report from the United Kingdom.

The study of doctor-owned companies premium comparisons includes four representative specialties. It shows premiums for \$1 million limit coverage except for Indiana, Michigan and Wisconsin where only lower limits are offered, and Ohio, where the limit is \$1.4 million. It is reprinted with permission of MIEC.

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ANALYSIS OF LATEST MD-COMPANY PREMIUM INCREASES REFLECTS TRENDS

Are medical insurance premiums finally leveling off? MLM's 1988 mid-year national survey of physician-owned companies reveals that premiums increased this year about 10% on average. Seventeen including four in California, reported no increases or increases less than 10%. Largest increases were reported by American Physicians Insurance Exchange of Texas (49.8%); Arizona (34.6%); Colorado (28.3%); Alaska (23.0%) and Georgia (21%).

Significant state tort reforms and a nationwide decline in the number of new claims filed in several regions may have contributed to the lower premium increases. The relatively modest overall increases, however, will nevertheless add some \$150 million to the aggregate annual insurance bill for some 170,000 physicians insured by these companies.

Next month MLM talks with some doctor-company leaders to find out whether this is a temporary or permanent downtrend--and why.

MLM 1988 MEDICAL MALPRACTICE INSURANCE RATE SURVEY

Doctor-companies offering \$1 million or more coverage

STATE/COMPANY	DATE CHANGE	PERCENTAGE INCREASE
Alabama	8/88	21.4 (Request filed)
Alaska	1/88	23.0
Arizona	4/88	34.6 (Request filed)
Arkansas	1/88	15.4
California		
MIBC	8/88	None
NORCAL		None
SCPIE	1/88	8.3
DOCTORS	4/88	None
Colorado	1/88	28.3
Connecticut	10/87	17.2
Dist. of Columbia	6/88	None (New renewal date: 1/1/89)
Florida		
FFIC	1/88	.5
FFIT	1/88	18.0
Georgia	5/88	21.0
Illinois	7/88	7.0
Iowa	2/88	17.7
Kentucky	4/88	10.0
Louisiana	7/88	None
Maine	9/87	25.0
Maryland	7/88	None (New renewal date: 1/1/89)
Michigan		
MMIC	4/88	9.8
Minnesota	1/88	8.0
Mississippi	1/88	15.0
Missouri		
MEMEDICO	9/87	15.0
New Jersey	2/88	None
New York	7/88	5.0
North Carolina	2/88	9.5
Ohio	8/88	10.0 (Request filed)
Oklahoma	1/88	5.0
Oregon	1/88	10.0
Tennessee	5/88	5.6
Texas		
APIE	1/88	49.8
Utah	12/87	4.5
Washington	1/88	9.0

Several physician-owned companies do not write coverage at \$1 million or more levels. They are not included in this report.

KANSAS PHYSICIANS, LAWYERS OFFER MODEL BILL... (Cont. from page 1)

panel conclusions strongly persuasive in determining the presence or absence of injury, the presence or absence of sub-standard practice, and the presence or absence of causation of such injury by substandard practice," the Kansas cardiovascular surgeon said.

Appeals from board decisions within the scope of the act go to state district courts and appellate courts, which must "act expeditiously by giving preference to the consideration of com-

MD firm rate survey...pp.2-3
PIE moves into MO.....p.4
New bill, OTA report....p.4
Checking competency.....p.5
Cadet diagnosis delay...p.6

two or three providers, are convened as needed to help the board evaluate claims."

"Although the board can make decisions independently, it is mandated to

FLORIDA INSURANCE COMMISSIONER ANNOUNCES FOR U.S. SENATE

It never was a secret that Florida Insurance Commissioner Bill Gunter had political ambitions. He now has announced that he will run for the U.S. Senate seat held by retiring Lawton Chiles. He will post-date his resignation until January, 1989, to prevent the Republican governor from appointing his successor.

PIE MUTUAL EXPANDS WESTWARD INTO MISSOURI: SEES RIGHT MIX

PIE Mutual Insurance Company, Cleveland, OH, has announced that it has been authorized to offer professional liability insurance to Missouri physicians through independent agents, beginning this month. PIE writes medical protection for 8,000 physicians, surgeons and dentists in Ohio, West Virginia and Kentucky.

"Missouri offers us the mix of ingredients which have worked well for our physicians in other states," said Larry E. Rogers, PIE's president and CEO. "The state has more than 11,000 physicians in a sophisticated medical community with a good track record of controlling costs."

The company will offer up to \$7.2/\$7.6 million in modified claims-made coverage. Rates have not yet been finalized.

CONGRESSIONAL BILL, REPORT FOCUS ON QUALITY CARE MEASURES

Congress currently appears to be taking a long and positive look at ways of improving the quality of medical care available to consumers.

Seeking to facilitate effective emergency medical treatment on certain commercial flights, Rep. William Broomfield (R-MI) has introduced legislation that would enable a physician to render care to a fellow passenger suffering a heart attack or similar life-threatening condition without fear of a malpractice suit. HR 4924, entitled the In-Flight Medical Emergency Assistance Act, would free a licensed MD from constraining malpractice liability when treating an in-flight emergency.

In addition, the Congressional Office of Technology Assessment last month issued a report offering possible guidelines that individuals and organizations can use to evaluate the quality of health care. Some yardsticks for measuring quality have become necessary, said Rep. James Scheuer (D-NY) in introducing the report, because of recent changes in physician and hospital reimbursement to hold down health costs.

"These payment changes have raised concerns that physicians and hospitals facing restricted budgets and low payment rates will skimp on services to the detriment of patients' health and that third-party payors will seek low cost providers with not enough regard for their quality of care," Rep. Scheuer, Chairman of the House Subcommittee on Natural Resources, Agriculture, Research and Environment, said.

OTA evaluated many possible quality care indicators and concluded that these were best: formal disciplinary actions by state medical boards; hospital accreditation standings; physicians practicing within the confines of their training; hospital mortality rates; adverse events, such as hospital-acquired infections; and sanctions imposed by the Department of Health and Human Services based on recommendations of peer review organizations. Amount of malpractice compensation also may be an indicator. Consumers' own ratings also have good validity, the report said, but patients should combine information from more than one indicator and draw information from more than one year. OTA also said high priority should be given to identifying and improving below-par performance of MDs and hospitals.

EXECUTIVE SUMMARY

Who Should Be Liable?

A Guide
To Policy For
Dealing
With Risk

This Executive Summary is
based on a Statement on
National Policy by the
Research and Policy
Committee of the Committee
for Economic Development

 CED

Who Should Be Liable?

A Guide To Policy For Dealing With Risk

In 1985 and 1986, our economy experienced what many called a "liability crisis." This crisis reverberated throughout the economy, raising prices and disrupting the supply of a wide range of goods, services, and activities. Today the crisis has eased to some degree, but that is not grounds for complacency. The root cause of the crisis — expanding and unpredictable standards of tort liability — has not yet been resolved.

Under our American system of governance, the tort liability system is intended to perform two functions: to deter the imposition of excessive risks on others and to compensate others for injuries received as a result. But new demands on the system have strained it to the point that in some circumstances it now neither effectively deters nor efficiently compensates. Designed in a simpler age, the tort system is neither prepared to resolve many of the increasingly complex issues and disputes that now confront it, nor is it designed to adapt efficiently to society's evolving standards of acceptable risk and fair compensation. **Consequently, we believe that the United States needs to develop a more balanced approach to risk management.** Such a balanced approach requires:

- Using the tort system, better structured to handle current issues, where it is most cost-effective.
- Putting increased reliance on other more cost-effective methods to control risk and provide compensation where the tort system is ill matched to the circumstances.

For purposes of controlling risk, the two most important alternatives to tort liability are **market forces** and **government regulation**. Greater reliance on market forces and government regulation can in some areas provide better **deterrence** than the liability system. For purposes of compensation, private insurance, social insurance, and workers' compensation are often far more efficient than liability and should play a greater role.

Our challenge is two-fold: first, to achieve the best balance between risk reduction and other social goals, such as more vigorous economic growth, higher standards of living, and greater job creation; second, to design the most cost-effective mix of institutions for controlling risk and providing compensation. Achieving these goals will not be possible, however, until we accept the need to modify our current practices.

DIMENSIONS OF THE PROBLEM

While the overall number of liability claims has grown only modestly in recent years, there has been an enormous increase in some types of cases. Between 1974 and 1985, for example, the number of product liability suits in federal courts increased more than seven-fold. At the same time, the number of suits involving professional and municipal liability has also grown dramatically. The largest growth has occurred in the area of so-called mass toxic torts, cases involving thousands of claims against a single product, notably asbestos, Agent Orange, and the Dalkon Shield. By 1986, for example, more than 350,000 Dalkon Shield claims had been submitted.

The size of awards has also skyrocketed. Since 1960, the typical award for product liability and medical malpractice suits has more than doubled, after adjusting for inflation, with much larger increases for the very highest awards.

Averages, however, do not tell the full story. Unpredictable variation in liability standards and awards from case to case and jurisdiction to jurisdiction greatly magnifies the sheer uncertainty confronting consumers, corporations, professionals, municipalities, not-for-profit organizations, and others who interact with the general public.

Because the potential scope and duration of liability and the size of awards have become virtually unbounded, those engaged in producing or delivering goods and services face extraordinary difficulties in taking such risks into account in their resource allocation and pricing decisions. For similar reasons, the insurance industry to which individuals and organizations typically come for liability coverage has had a difficult time pricing risk, and liability insurance rates have increased sharply. Medical malpractice rates have increased 25 to 40 percent a year since 1985. Rates have increased several hundred percent in the space of one or two years for some groups of insureds, while other buyers report being unable to obtain the amount of coverage they would prefer.

Plaintiffs receive only a fraction of the total dollars expended through the tort system. Of the \$19.5 billion spent on non-auto cases in 1985, \$11 billion went to litigation costs, including attorneys' fees and time costs of the litigants, leaving only \$8.2 billion in compensation to plaintiffs. On average, the litigation process for non-auto cases absorbs roughly 57 percent of total expenditures.

The costs of lawsuits and liability insurance premiums are only a fraction of the total costs of the liability system. Much harder to measure are the indirect costs of loss of productivity and international competitiveness, and the loss to consumers from goods and services that are withdrawn or simply not produced. Many U.S. firms incur much greater insurance costs than their foreign competitors. Total U.S. liability insurance costs, for example, exceed those of Japan by a factor of fifteen. Such high costs have forced some American companies out of certain high-risk markets. Moreover, nearly half of the large firms and two-thirds of small firms which responded to a recent Conference Board survey report that the increased threat of liability had significantly curtailed their provision of products and services.

Unfortunately, the available data are inadequate to measure the full costs and the benefits of the liability system. Some withdrawal of risky products is expected—indeed intended—under a well-functioning liability system, and some expenditures on dispute resolution are inevitable. But in our judgment, there is good reason to believe that the current drift in liability rules leads to distortions in production, withdrawal of products that optimally should be marketed, and wasteful litigation costs. We believe the partial data and practical experience available today permit us to reach reasonable judgments on ways of improving our systems of risk management and deterrence.

CAUSES OF THE PROBLEM

Chiefly through a succession of court cases, liability for personal injury has been expanded from a fault-based standard to strict and increasingly to absolute liability. Manufacturers can be held liable for risks that were scientifically unknowable at the time of production. Furthermore, they can be found liable if the plaintiff wantonly misused the product, if other parties contributed to the injury, and even if no connection was established between a defendant's actions and a plaintiff's injury. Employees covered by workers' compensation have been allowed to sue in tort even though participation in the program was originally intended to be a bar to such suits.

Imposing liability where a defendant has taken all reasonable precautions serves no positive deterrent function—on the contrary, it undermines the incentive for other parties to take appropriate care and may lead to the withdrawal of products that cannot be designed to prevent misuse.

Risk reduction has been one goal driving the expansion of liability. But in setting standards of liability or regulation, it is essential to recognize that zero risk is neither technically possible nor financially feasible due to our limited resources. Because of these resource constraints, we need to make more clear-cut and rational decisions on the trade-

offs we will accept between risk reduction and other social goals we also hold dear. It is also essential to recognize that when more than two parties can reduce or aggravate risk, optimal risk management requires providing all with incentives to take appropriate care.

More complete **compensation** has been another goal driving the expansion of liability. But expanding liability in order to compensate is grounded in the mistaken belief that defendants can spread this risk at minimal cost. In fact, the costs of increased tort compensation are largely passed on to consumers through higher prices, and in some cases, through the decreased availability of useful products and services.

But providing compensation through the courts is extremely inefficient. Lawsuits provide less compensation per dollar spent than any form of insurance: plaintiffs receive only 40 cents per dollar spent on lawsuits while workers' compensation pays the injured party roughly 60 cents per cost dollar and private health insurance pays over 80 cents per cost dollar. Moreover, lawsuits often take months or years to settle before any award is made. In addition, tort compensation is a poor form of insurance because awards are highly uncertain in amount and timing and often simply duplicate other private and social insurance payments.

RECOMMENDATIONS

Using the liability system is only one of several approaches to achieving the goals of efficient and equitable risk management, injury compensation, and dispute resolution. Market incentives, public regulation, private health and disability insurance, social insurance, and workers' compensation all have important roles to play in how the United States deals with risk. **Our goal should be to improve the cost-effectiveness of each of these mechanisms and to ensure their efficient integration.**

Achieving these goals will require extensive efforts by Congress, state legislatures, the courts, the legal profession, manufacturers, and insurers. If well-designed, our courts, regulatory agencies, and social and private insurance programs can mesh with one another and with market forces to jointly control risk and compensate injury appropriately. But if they remain poorly designed and uncoordinated, these potentially useful corrective forces can generate wasteful and draining distortions on our economy.

The following is a summary of our key recommendations to prevent such waste. Other changes are also needed; they are discussed in greater detail in our full report. We have included a limited glossary at the end explaining some of the legal terms used below.

A. CHOICE OF INSTITUTIONS

We strongly believe that when consumers and workers are reasonably well informed, market forces can provide appropriate incentives to control risk. However, when market forces produce insufficient incentives for safety—either because risks are latent or third parties are affected—the control of excessive risk by tort* liability or regulation should be considered. Managing risk by regulation is more appropriate than tort liability in circumstances that call for uniform standards based on technical expertise beyond the competence of the typical consumer and the typical juror, or where damages are highly diffuse or distant in time or place from the harmful activity.

- Courts should honor contractual agreements between well informed parties. This would include disallowing suits where risks were obvious to the parties and adhering to liability insurance and other contractual agreements.
- Standard setting by existing regulatory agencies such as OSHA, EPA, and the FDA should be the main instrument for controlling environmental and chemical hazards, pharmaceuticals, and medical devices.
- Compliance with regulatory standards of product design or warning should be a bar to tort liability, except in cases of fraud or suppression of evidence.
- The workers' compensation (WC) system should be the sole remedy for work-related injuries and diseases where occupational exposure is the predominant cause. Tort actions should be disallowed, because market forces, regulation, and the WC system provide strong incentives for risk control. To assure fair compensation for work-related injuries, WC benefits should provide for full replacement of after-tax earnings and reasonable medical and rehabilitation expense, and should be indexed to keep pace with inflation.

B. REFORM OF THE TORT SYSTEM

The primary goal of tort liability, when used, should be to create efficient incentives to all relevant parties to control risk. Deterring excessive risk should override concern for compensation if these two goals conflict, because of the greater cost to society of not deterring risk properly and because other insurance mechanisms are more cost-effective if compensation is the main concern. To the extent possible, tort standards should be gov-

*See Glossary

erned by clear and predictable rules. This is essential for efficient deterrence and compensation and to reduce expenditure on litigation. Several of our recommendations apply to all areas of tort liability. Others are specific to product liability.

1. GENERAL RECOMMENDATIONS

- Liability should be based on a notion of fault or failure to take cost-justified precautions.
- Joint and several liability* should be eliminated. Joint and several liability violates the deterrent principle of assessing costs to responsible parties. It encourages the frivolous naming of deep pocket* defendants who can now be held fully liable even if only minimally responsible. It also limits the ability of insurers to perform accurate risk assessment.
- A state-of-the-art defense* and a reasonable statute of repose* are required to prevent retroactive application of new knowledge and new standards of liability. Liability imposed retroactively for unknowable risk cannot usefully deter.
- Compensatory awards should be modeled along the same lines as private and social insurance. Specific guidelines (indexed for inflation) should be set by statute for both monetary and nonmonetary loss. Narrowing the discretion of the courts would make awards more equitable, reduce incentives for litigation, and reduce uncertainty for all parties concerned.
- Compensatory awards for monetary loss should aim to replace after-tax wages (with special provisions for persons not in the labor force) and cover appropriate medical, rehabilitation, and special educational expenses. Payments for nonmonetary loss should be reasonable and made according to a schedule based on the plaintiff's age and severity of injury.
- Tort and nontort insurance coverages need to be better coordinated, but more fact-finding and study is needed to determine the best method of coordination.
- Punitive damages should be awarded only in cases of willful misconduct* and should be limited to a modest multiple of the compensatory awards. Punitive damages should be coordinated across different cases relating to the same issue.
- Aggressive judicial management should be used to prevent strategic abuse of pretrial tactics. Judges should not allow unsubstantiated testimony of expert witnesses, should be more willing to grant summary judgment, should send to the jury only those issues that are truly within the jury's realm of expertise, and should consider reducing excessive awards.

*See Glossary

2. PRODUCT LIABILITY

- A federal product liability statute should be enacted. The current diversity of state standards generates costly and inefficient uncertainty.
- Courts should disallow or modify liability if a product is unreasonably misused, altered, or used in a way contrary to explicit warnings.

3. INTERNATIONAL RIGHTS AND RESPONSIBILITIES

- All U.S. courts should deny access to foreign litigants for injuries occurring outside of the United States, as most federal courts already do. Foreign sellers of products in the United States should be subject to financial responsibility requirements as stringent as those applied to U.S. firms. These principles will assure both U.S. and foreign consumers the same tort rights against foreign-based suppliers as against domestic firms.

4. NONOCCUPATIONAL MASS TORTS

- Further study is needed to determine the best way to handle the unique and highly complex problems raised by mass tort cases. Our tentative recommendation is that such claims should be permitted only where the contribution to injury by the defendant exceeds some threshold. Alternatively, damages paid by the defendant could be reduced by the percentage contribution of other factors.

C. STANDARD SETTING THROUGH REGULATION

- The goal of regulatory standards should be to achieve roughly equal marginal benefits in terms of life-years saved per dollar spent for all types of hazards.
- Performance standards should be set in terms of target quality or risk levels. Regulations requiring specific process standards destroy incentives for developing new methods that can achieve the desired result at lower cost.

D. ALTERNATIVE DISPUTE RESOLUTION

There are abundant opportunities for reducing the costs and delay of dispute resolution through one or another of various alternatives to court trials that are being developed around the country. We recommend:

- Parties should be permitted and encouraged to contractually adopt alternative systems of dispute resolution (ADR) such as arbitration, mediation, and mini-trials, provided that such contracts clearly state where rights to a jury trial are being waived.

E. ALTERNATIVE COMPENSATION PROGRAMS

- Because the tort system has much higher overhead costs than other insurance programs, it should be used for purposes of compensation only where it can also perform a useful deterrent function.
- For those without adequate coverage for injury, expanding existing private or social insurance programs is preferable to creating new programs targeted at specific injuries.

Our current mix of institutions for risk control and injury compensation has evolved in an uncoordinated fashion that entails much wasteful duplication and even inconsistent standards, and at the same time leaves many legitimate needs inadequately attended. Correcting these large-scale inefficiencies and inequities requires statutory, judicial, and regulatory changes, as well as private initiatives. It also requires more comprehensive coordination among these public and private systems. A more systematic approach is essential to halt the trends which lead the liability system to attempt to perform functions it is not designed to perform and which can be achieved far more efficiently through other means. We believe this study points the way to such a goal.

GLOSSARY

Deep pocket defendant: A defendant with relatively large financial assets or insurance.

Joint and several liability: A rule that permits a plaintiff to collect the full amount of damages from any single defendant, in cases where multiple defendants are found to have contributed to the injury, regardless of the relative fault of each defendant.

State-of-the-art defense: A defense which bars suits if the defendant complied with standards of care or a product was not defective, given the state of knowledge and what was reasonably knowable at the time of the defendant's action.

Statute of limitation: A statute prescribing a specified period of time in which a lawsuit can be filed, sometimes running from the date at which the plaintiff discovered (or should have discovered) the injury.

Statute of repose: A limit on the time within which a suit may be brought, with the limit defined from the date of the defendant's alleged harmful act, as opposed to the date the plaintiff discovered the injury (see statute of limitation).

Tort: A private or civil wrong or injury other than breach of contract, for which redress in the form of damages can be sought under common law.

Willful misconduct: Conduct which intentionally and voluntarily disregards the safety of others, such as failure after knowledge of an impending danger to exercise ordinary care to prevent it.

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Official Title and Summary Prepared by the Attorney General

INSURANCE RATES, REGULATION, COMMISSIONER. INITIATIVE STATUTE Requires minimum 20-percent rate reduction from November 8, 1987, levels, for automobile and other property/casualty insurance. Freezes rates until November 8, 1989, unless insurance company is substantially threatened with insolvency. Thereafter requires every insurer offer any eligible person a good-driver policy with 20-percent differential. Requires public hearing and approval by elected Insurance Commissioner for automobile, other property/casualty insurance rate changes. Requires automobile premiums be determined primarily by driving record. Prohibits discrimination, price-fixing, unfair practices by insurance companies. Requires commissioner provide comparative pricing information. Authorizes insurance activities by banks. Summary of Legislative Analyst's estimate of net state and local government impact: Would increase Department of Insurance administrative costs by \$10 to \$15 million in first year, varying thereafter with workload, to be paid by additional fees on the insurance industry. State and some local governments would have unknown savings from lower insurance rates. Gross premium tax reduction of approximately \$125 million for first three years offset by required premium tax rate adjustment. Thereafter, possible state revenue loss if rate reductions and discounts continue but gross premium tax is not adjusted.

Analysis by the Legislative Analyst

Background

Various types of insurance are sold in California, including automobile, liability, fire, health and life. In 1987, companies collected about \$50 billion in premiums from the sale of insurance. In turn, the state received about \$1 billion from a tax on these premiums.

Motor vehicle insurance is one of the major types of insurance purchased in the state. It accounted for about \$12 billion (24 percent) of all premiums collected during 1987. Additionally, fire and liability insurance premiums totaled about \$10 billion, or 21 percent, of all premiums.

Rate Setting by Insurance Companies. Currently, insurance companies set rates for various types of insurance, using a number of factors. For motor vehicle insurance, these factors generally include the age, sex, marital status, driving record, type of vehicle and home address of the insured. The insurance companies also take into consideration other factors such as their claims experience, income and expenses. Insurance companies are not required to tell the public what relative weight they give to these factors when setting rates. In addition, insurance companies are not subject to the state's anti-trust laws.

Role of the Department of Insurance in Reviewing Rates. Currently, the Department of Insurance does not review and approve insurance rate changes before they take effect. Instead, the Department of Insurance can request insurance companies to justify such rates *after* they take effect, as part of the rate examination process or in response to complaints from consumers. Historically, the scope and frequency of rate examinations has been limited.

Proposal

In summary, this measure:

- Requires insurance companies to reduce rates for various types of insurance, including motor vehicle, fire and liability.
- Requires insurance companies to offer a "Good Driver Discount Plan" and makes other changes regarding automobile insurance.

- Requires the Insurance Commissioner to review and approve rate increases—for various types of insurance—before they can take effect.
- Requires that the Insurance Commissioner be elected.

This measure changes the laws that regulate insurance rates for certain types of insurance. It applies to motor vehicle, fire and liability insurance, but not to life, mortgage and disability insurance.

Rate Reductions

1. Rate Reduction. This measure requires that rates for motor vehicle, fire and liability insurance issued or renewed on or after November 8, 1988, be reduced by 20 percent from their levels on November 8, 1987.

2. Rate Freeze. The measure requires that the rates be kept at the reduced levels until November 8, 1989. During this period, the rates can be increased only if the Insurance Commissioner determines that the affected insurance company is threatened with insolvency.

Review and Approval of Insurance Rate Filings

Beginning November 8, 1989, the measure requires the Insurance Commissioner to review and approve rate changes before they go into effect. Insurance companies are required to file information with the commissioner to justify the new rates. In general, the commissioner is required to hold a public hearing on the proposed rate change whenever it exceeds certain percentages. Additionally, the commissioner is authorized to hold a hearing when requested by a consumer.

Good Driver Discount Plan and Other Automobile Provisions

1. "Good Driver" Discount. This measure requires insurance companies to offer motor vehicle insurance to good drivers at reduced rates. These rates would take effect November 8, 1989, (one year after the general rate reduction) and would be 20 percent below the rate which would otherwise have been paid for the same coverage.

Continued on page 140

Text of Proposed Law

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8 of the Constitution.

This initiative measure adds and repeals sections of the Insurance Code, and adds a section to the Revenue and Taxation Code; therefore, existing sections proposed to be deleted are printed in ~~strikeout type~~ and new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

SECTION 1. Findings and Declaration.

The People of California find and declare as follows:

Enormous increases in the cost of insurance have made it both unaffordable and unavailable to millions of Californians.

The existing laws inadequately protect consumers and allow insurance companies to charge excessive, unjustified and arbitrary rates.

Therefore, the People of California declare that insurance reform is necessary. First, property-casualty insurance rates shall be immediately rolled back to what they were on November 8, 1987, and reduced no less than an additional 20%. Second, automobile insurance rates shall be determined primarily by a driver's safety record and mileage driven. Third, insurance rates shall be maintained at fair levels by requiring insurers to justify all future increases. Finally, the state Insurance Commissioner shall be elected. Insurance companies shall pay a fee to cover the costs of administering these new laws so that this reform will cost taxpayers nothing.

SECTION 2. Purpose.

The purpose of this chapter is to protect consumers from arbitrary insurance rates and practices, to encourage a competitive insurance marketplace, to provide for an accountable Insurance Commissioner, and to ensure that insurance is fair, available, and affordable for all Californians.

SECTION 3. Reduction and Control of Insurance Rates.

Article 10, commencing with Section 1861.01 is added to Chapter 9 of Part 2 of Division 1 of the Insurance Code to read:

Insurance Rate Rollback

1861.01. (a) For any coverage for a policy for automobile and any other form of insurance subject to this chapter issued or renewed on or after November 8, 1988, every insurer shall reduce its charges to levels which are at least 20% less than the charges for the same coverage which were in effect on November 8, 1987.

(b) Between November 8, 1988, and November 8, 1989, rates and premiums reduced pursuant to subdivision (a) may be only increased if the commissioner finds, after a hearing, that an insurer is substantially threatened with insolvency.

(c) Commencing November 8, 1989, insurance rates subject to this chapter must be approved by the commissioner prior to their use.

(d) For those who apply for an automobile insurance policy for the first time on or after November 8, 1988, the rate shall be 20% less than the rate which was in effect on November 8, 1987, for similarly situated risks.

(e) Any separate affiliate of an insurer, established on or after November 8, 1987, shall be subject to the provisions of this section and shall reduce its charges to levels which are at least 20% less than the insurer's charges in effect on that date.

Automobile Rates & Good Driver Discount Plan

1861.02. (a) Rates and premiums for an automobile insurance policy, as described in subdivision (a) of Section 660, shall be determined by application of the following factors in decreasing order of importance:

(1) The insured's driving safety record.

(2) The number of miles he or she drives annually.

(3) The number of years of driving experience the insured has had.

(4) Such other factors as the commissioner may adopt by regulation that have a substantial relationship to the risk of loss. The regulations shall set forth the respective weight to be given each factor in determining automobile rates and premiums. Notwithstanding any other provision of law, the use of any criterion without such approval shall constitute unfair discrimination.

(b) (1) Every person who (A) has been licensed to drive a motor vehicle for the previous three years and (B) has had, during that period, not more than one conviction for a moving violation which has not eventually been dismissed shall be qualified to purchase a Good Driver Discount policy from the insurer of his or her choice. An insurer shall not refuse to offer and sell a Good Driver Discount policy to any person who meets the standards of this subdivision. (2) The rate charged for a

Good Driver Discount policy shall comply with subdivision (a) and shall be at least 20% below the rate the insured would otherwise have been charged for the same coverage. Rates for Good Driver Discount policies shall be approved pursuant to this article.

(c) The absence of prior automobile insurance coverage, in and of itself, shall not be a criterion for determining eligibility for a Good Driver Discount policy, or generally for automobile rates, premiums, or insurability.

(d) This section shall become operative on November 8, 1989. The commissioner shall adopt regulations implementing this section and insurers may submit applications pursuant to this article which comply with such regulations prior to that date, provided that no such application shall be approved prior to that date.

Prohibition on Unfair Insurance Practices

1861.03. (a) The business of insurance shall be subject to the laws of California applicable to any other business, including, but not limited to, the Unruh Civil Rights Act (Civil Code Sections 51 through 53), and the antitrust and unfair business practices laws (Parts 2 and 3, commencing with section 16600 of Division 7, of the Business and Professions Code).

(b) Nothing in this section shall be construed to prohibit (1) any agreement to collect, compile and disseminate historical data on paid claims or reserves for reported claims, provided such data is contemporaneously transmitted to the commissioner, or (2) participation in any joint arrangement established by statute or the commissioner to assure availability of insurance.

(c) Notwithstanding any other provision of law, a notice of cancellation or non-renewal of a policy for automobile insurance shall be effective only if it is based on one or more of the following reasons: (1) non-payment of premium; (2) fraud or material misrepresentation affecting the policy or insured; (3) a substantial increase in the hazard insured against.

Full Disclosure of Insurance Information

1861.04. (a) Upon request, and for a reasonable fee to cover costs, the commissioner shall provide consumers with a comparison of the rate in effect for each personal line of insurance for every insurer.

Approval of Insurance Rates

1861.05. (a) No rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter. In considering whether a rate is excessive, inadequate or unfairly discriminatory, no consideration shall be given to the degree of competition and the commissioner shall consider whether the rate mathematically reflects the insurance company's investment income.

(b) Every insurer which desires to change any rate shall file a complete rate application with the commissioner. A complete rate application shall include all data referred to in Sections 1857.7, 1857.9, 1857.15, and 1864 and such other information as the commissioner may require. The applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this article.

(c) The commissioner shall notify the public of any application by an insurer for a rate change. The application shall be deemed approved sixty days after public notice unless (1) a consumer or his or her representative requests a hearing within forty-five days of public notice and the commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision, or (2) the commissioner on his or her own motion determines to hold a hearing, or (3) the proposed rate adjustment exceeds 7% of the then applicable rate for personal lines or 15% for commercial lines, in which case the commissioner must hold a hearing upon a timely request.

1861.06. Public notice required by this article shall be made through distribution to the news media and to any member of the public who requests placement on a mailing list for that purpose.

1861.07. All information provided to the commissioner pursuant to this article shall be available for public inspection, and the provisions of Section 6254(d) of the Government Code and Section 1857.9 of the Insurance Code shall not apply thereto.

1861.08. Hearings shall be conducted pursuant to Sections 11500 through 11528 of the Government Code, except that: (a) hearings shall be conducted by administrative law judges for purposes of Sections 11512 and 11517, chosen under Section 11502 or appointed by the commissioner; (b) hearings are commenced by a filing of a Notice in lieu of Sections 11503 and 11504; (c) the commissioner shall adopt,

Continued on page 140

Argument in Favor of Proposition 103

There are important differences between the five insurance initiatives on the November ballot which you should be aware of before voting.

Proposition 103—Voter Revolt to Cut Insurance Rates—is the only insurance initiative written and paid for exclusively by consumers. It alone reduces all of your automobile, home and business insurance premiums to November 1987 prices. Then, it alone cuts them another 20%.

Proposition 103 will also end the insurers' exemption from the antimonopoly laws, allow people to elect the Insurance Commissioner, require a special 20% discount for good drivers, and stop unfair price increases in the future. It specifies that a permanent, independent consumer watchdog system will champion the interests of insurance consumers.

Proposition 103 is written in plain language. There are no loopholes or fine print. Unlike the other propositions, nonlawyers can read it.

Because the polls showed that the insurance industry could not defeat Voter Revolt's 103 directly, the insurance companies came up with a plan to defeat it indirectly. They are pushing Proposition 104—the so-called "no-fault" proposition—and are spending tens of millions of dollars to advertise that it is better for consumers than Proposition 103.

Privately, insurance executives have admitted that their Proposition 104 would actually raise auto insurance premiums for many drivers. Worse, Proposition 104 rewrites the entire California Insurance Code to benefit insurance companies. The 24,000 words of obscure legalese in Proposition 104 turn the law into a "your fault" system. Their fine print cancels out every consumer reform in Voter Revolt's Proposition 103.

Some insurance companies disagree with "no fault," so they're financing Proposition 101, which claims to make the biggest cut in auto insurance. But the big cut they boast about affects only one portion of your auto insurance—they could raise premiums for the rest of your coverage as much as they want. In return, Proposition 101 allows insurance companies to avoid full payment for accidents. It, too, cancels many of the auto insurance reforms in Proposition 103.

Insurance companies are also financing Proposition 106, which restricts your right to quality legal counsel. The insurance companies claim Proposition 106 will cut their costs. In fact, it will limit your ability to make the insurance companies pay up.

Proposition 100, which is paid for by trial lawyers and bankers, simply does not go far enough to protect consumers' interests. Unlike Proposition 103, it does not automatically and immediately cut insurance rates. Nor does it enable consumers to permanently unite to fight against insurance abuse, as Voter Revolt's Proposition 103 does.

Proposition 103 is the only initiative written and paid for exclusively by consumers. It will save you the most money.

To guarantee that every reform in Voter Revolt's Proposition 103 becomes law, it must get more "Yes" votes than any other proposition. Every vote in favor of another insurance proposition cancels your vote for Proposition 103. That's why we advise you to vote "Yes" *only* on Proposition 103.

RALPH NADER
Consumer Advocate

HARVEY ROSENFELD
*Chair, Voter Revolt to Cut Insurance Rates/
Proposition 103*

Rebuttal to Argument in Favor of Proposition 103

Proponents of PROP 103 claim that their initiative includes no "fine print," but IT'S FULL OF UNINTENDED CONSEQUENCES THAT WILL WIPE OUT ANY BENEFITS IT PROMISES YOU. VOTE NO ON PROP 103.

The most glaring example of this "fine print" allows for massive government intervention into the insurance industry. A GOVERNMENT-RUN INSURANCE SYSTEM IS NOT THE ANSWER.

In New Jersey, where the government intervened in the insurance business under circumstances similar to those mandated in PROP 103, every driver is paying a surcharge to help foot a \$2.5-billion deficit racked up by the state-run insurance system.

PROP 103 advocates also tell you their initiative contains no loopholes. Look again. It's loaded with them.

- **RATES WILL INCREASE** by an average 22% for two-thirds of the state's drivers, according to the State Department of Insurance, because PROP 103

eliminates rating based on the driving safety record of your neighborhood and forces suburban and rural drivers to subsidize motorists in high-risk areas.

- **DRUNK DRIVERS** who haven't lost their licenses can qualify for "good driver" discounts.

A MASSIVE BUREAUCRACY IS NOT THE SOLUTION. Only fundamental reform of our auto insurance system will hold down insurance premiums. We need to reduce the cost of litigation, fraud and subsidizing uninsured motorists.

PROP 103 DOES NOT REFORM OUR SYSTEM. IT DOES NOT GUARANTEE YOU LONG-TERM RATE REDUCTIONS.

Vote NO on PROP 103.

ALISTER MCALISTER
Former Chair, Assembly Finance and Insurance Committee

ED DAVIS
State Senator, 19th District

KIRK WEST
President, California Chamber of Commerce

Argument Against Proposition 103

KEEP BIG GOVERNMENT OUT OF THE AUTO INSURANCE BUSINESS.

You might think PROP 103's auto insurance rate reductions seem too good to be true. You're right.

Vote NO on PROP 103; it does not enact any cost-cutting reforms. Instead, it attacks the symptoms of our failing auto insurance system. It does not address, let alone begin to grapple with, the real problem—the cost of uninsured motorists, fraud and, most importantly, *run-away auto accident litigation*.

PROP 103 might seem well-intentioned but, unfortunately, it inevitably would lead to a huge, state-run insurance system costing millions of dollars.

Hidden provisions of this measure give the state unprecedented authority to enter the insurance business. If you think lines are long and the bureaucracy impenetrable at government offices today, just wait until you have to deal with the state to purchase insurance.

This sloppily drafted measure will:

- *Raise insurance premiums, in the long term, for the majority of California drivers.* PROP 103 forces insurers to ignore the driving safety record of where you live and, instead, forces you to subsidize drivers in areas that have the highest insurance losses. For example, a 55-year-old suburban driver will end up paying more for insurance so that a young urban driver can pay less. A State Department of Insurance study recently predicted that this aspect of PROP 103 will raise rates for two-thirds of the state's drivers

by an average 22%!

- *Allow convicted drunk drivers who have not lost their licenses to win an additional rate discount for "good driving."*
- *Make the Insurance Commissioner an elected official with enormous new powers.* This "insurance czar" would be a politician first, and a regulator second. As a politician, this official would be preoccupied with raising campaign money from special interests all too willing to "buy" influence.
- *Create a huge government bureaucracy that does nothing to make auto insurance more affordable.* Instead, PROP 103 would add time, expense and lots of lawyers to enact a price-control policy that has failed miserably in New Jersey and other states. To carry out this price-control policy, the measure increases the Department of Insurance's budget by 33% and its staff by at least 100 new bureaucrats.

VOTE NO on PROP 103. Lowering auto premiums for California drivers is a laudable goal, but this measure's flawed methods are not the answer. Please VOTE NO on PROP 103.

KIRK WEST

President, California Chamber of Commerce

WILLIAM CAMPBELL

State Senator, 31st District

Chairman, Joint Legislative Budget Committee

DAVID DAVREUX

Author, Consumers' Guide to Auto Insurance

Rebuttal to Argument Against Proposition 103

The insurance companies want to divert your attention away from the fact that Prop 103 will save *everyone* 20% on their auto insurance as well as their home and business insurance. That's why the statement above employs confusing and often ridiculous arguments against it.

Here are the facts:

- 103 is the *only* initiative that will immediately cut *everyone's* premiums by 20%.
- 103 forces insurance companies to base your rates on your driving record first, rather than on where you live. That means good drivers throughout the state will pay less than they do now, while bad drivers will pay more.
- 103 eliminates the insurance industry's unfair exemption from the antitrust laws. This will reduce rates permanently.
- 103 involves no new government bureaucracy—just a

new set of rules to create a competitive marketplace and prohibit excessive rates.

- 103 will actually save money for taxpayers, according to the official California State Legislative Analyst.
- And no wonder the insurance companies don't want an elected Insurance Commissioner—in the states where people elect insurance commissioners, rates average 30% lower than in California.

Voter Revolt's Proposition 103 is the *only* insurance reform initiative written and paid for exclusively by consumers. That's why it is the *only* initiative endorsed by Ralph Nader.

103 will lower insurance rates for everyone. That's why the insurance industry is against it. Don't buy their misleading advertising. Vote YES on Proposition 103.

HARVEY ROSENFELD

*Chair, Voter Revolt to Cut Insurance Rates/
Proposition 103*

Proposition 103: Analysis

Continued from page 98

In general, this measure defines a good driver as a person who, during the last three years, has (a) held a driver's license and (b) had no more than one conviction for a moving violation.

2. Determining Factors for Rates. In general, the measure requires that rates and premiums for automobile insurance be determined on the basis of the insured person's driving record, miles driven and number of years of driving experience.

Other Insurance-Related Provisions

1. Antitrust Laws. The measure makes insurance companies subject to the state's antitrust laws.

2. Election of Insurance Commissioner. The measure requires that the Insurance Commissioner be elected, the first election taking place in 1990.

3. Consumer Assistance. The measure requires the establishment of a nonprofit corporation to represent the interests of insurance consumers. Additionally, the measure requires the Insurance Commissioner to provide consumers—upon request and for a reasonable fee—with a comparison of the rates for *each* personal (that is, noncommercial) type of insurance offered in California. In general, this would include rates for private automobile, homeowner's and renter's insurance.

4. Discounts or Rebates. The measure permits insurance agents and brokers to give certain discounts or rebates to those who buy insurance from them. It does so, by eliminating the prohibition in current law against such discounts or rebates.

Fiscal Effect

Costs

Department of Insurance. This measure would increase the Department of Insurance's administrative costs by between \$10 million to \$15 million during 1988-89. These costs would be financed out of the Insurance Fund which is supported by fees and assessments on

the insurance industry. Given the current balance in this fund, fees and assessments would have to be increased to cover these costs.

In years following, these costs could be somewhat lower or higher, depending on workload.

State and Local Governments. While some local governments purchase insurance, most "self-insure" by relying upon their own resources to pay losses and claims. The state is generally self-insured, but does purchase some liability and fire insurance. Because this measure reduces the rates for certain types of insurance, including motor vehicle, fire and liability, it would result in unknown savings to the state and those local governments that purchase such insurance.

Revenues

Insurance companies pay a tax based on the amount of gross premiums they receive each year from insurance sold in California. These tax revenues are deposited in the State General Fund.

Starting in November 1988, this measure requires that rates for motor vehicle, fire and liability insurance be reduced. These lines of insurance account for about 45 percent of all California insurance premiums. A good driver discount takes effect a year later. The Department of Insurance's new role in reviewing and approving proposed rate changes also takes effect in November 1989. The rate reductions and the good driver discounts combined normally would reduce state insurance tax revenues by about \$125 million a year. This estimate assumes that about 50 percent of the drivers would qualify for the discount. It also assumes that no offsetting adjustments would be made in other insurance rates. The resulting state revenue loss, however, will not occur because this measure provides that for the period November 1988 to January 1991 the State Board of Equalization shall adjust the state tax rate on gross premiums to offset these premium reductions.

Thereafter, there would be an unknown General Fund revenue loss to the extent these rate reductions and discounts continue.

Proposition 103: Text of Proposed Law

Continued from page 99

amend or reject a decision only under Section 11517 (c) and (e) and solely on the basis of the record; (d) Section 11513.5 shall apply to the commissioner; (e) discovery shall be liberally construed and disputes determined by the administrative law judge.

1861.09. Judicial review shall be in accordance with Section 1858.6. For purposes of judicial review, a decision to hold a hearing is not a final order or decision; however, a decision not to hold a hearing is final.

Consumer Participation

1861.10. (a) Any person may initiate or intervene in any proceeding permitted or established pursuant to this chapter, challenge any action of the commissioner under this article, and enforce any provision of this article.

(b) The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that (1) the person represents the interests of consumers, and, (2) that he or she has made a substantial contribution to the adoption of any order, regulation or decision by the commissioner or a court. Where such advocacy occurs in response to a rate application, the award shall be paid by the applicant.

(c) (1) The commissioner shall require every insurer to enclose notices in every policy or renewal premium bill informing policyholders of the opportunity to join an independent, non-profit corporation which shall advocate the interests of insurance consumers in any forum. This organization shall be established by an interim board of public members designated by the commissioner and operated by individuals who are democratically elected from its membership. The corporation shall proportionately reimburse insurers for any additional costs incurred by insertion of the enclosure, except no postage shall be charged for any enclosure weighing less than $\frac{1}{4}$ of an ounce. (2) The commissioner shall by regulation determine the content of the enclosures and other procedures necessary for implementation of this provision. The legislature shall make no

appropriation for this subdivision.

Emergency Authority

1861.11. In the event that the commissioner finds that (a) insurers have substantially withdrawn from any insurance market covered by this article, including insurance described by Section 660, and (b) a market assistance plan would not be sufficient to make insurance available, the commissioner shall establish a joint underwriting authority in the manner set forth by Section 11891, without the prior creation of a market assistance plan.

Group Insurance Plans

1861.12. Any insurer may issue any insurance coverage on a group plan, without restriction as to the purpose of the group, occupation or type of group. Group insurance rates shall not be considered to be unfairly discriminatory, if they are averaged broadly among persons insured under the group plan.

Application

1861.13. This article shall apply to all insurance on risks or on operations in this state, except those listed in Section 1851.

Enforcement & Penalties

1861.14. Violations of this article shall be subject to the penalties set forth in Section 1859.1. In addition to the other penalties provided in this chapter, the commissioner may suspend or revoke, in whole or in part, the certificate of authority of any insurer which fails to comply with the provisions of this article.

SECTION 4. Elected Commissioner

Section 12900 is added to the Insurance Code to read:

12900. (a) The commissioner shall be elected by the People in the same time, place and manner and for the same term as the Governor.

SECTION 5. Insurance Company Filing Fees

Section 12979 is added to the Insurance Code to read:

12979. Notwithstanding the provisions of Section 12978, the commissioner shall establish a schedule of filing fees to be paid by insurers to cover any

administrative or operational costs arising from the provisions of Article 10 (commencing with Section 1861.01) of Chapter 9 of Part 2 of Division 1.

SECTION 6. Transitional Adjustment of Gross Premiums Tax

Section 12902.1 is added to the Revenue & Taxation Code to read:
12902.1. Notwithstanding the rate specified by Section 12902, the gross premium tax rate paid by insurers for any premiums collected between November 8, 1988 and January 1, 1991 shall be adjusted by the Board of Equalization in January of each year so that the gross premium tax revenues collected for each prior calendar year shall be sufficient to compensate for changes in such revenues, if any, including changes in anticipated revenues, arising from this act. In calculating the necessary adjustment, the Board of Equalization shall consider the growth in premiums in the most recent three year period, and the impact of general economic factors including, but not limited to, the inflation and interest rates.

SECTION 7. Repeal of Existing Law

Sections 1643, 1850, 1850.1, 1850.2, 1850.3, 1852, 1853, 1853.6, 1853.7, 1857.5, 12900, Article 3 (commencing with Section 1854) of Chapter 9 of Part 2 of Division 1, and Article 5 (commencing with Section 750) of Chapter 1 of Part 2 of Division 1, of the Insurance Code are repealed.

1643. No bank or bank holding company, subsidiary, or affiliate thereof, or any officer or employee of a bank, bank holding company, subsidiary, or affiliate, may be licensed as an insurance agent or broker or act as an agent or broker for insurance; in this state, or control a licensed insurance agent or broker, except that a bank or a bank holding company, subsidiary, or affiliate of a bank, may be issued a license to act as a life and disability agent limited to the transaction of credit life and disability insurance; or an agent limited to the transaction of insurance which is limited solely to securing repayment of the outstanding balance due on a specific extension of credit by a bank or bank holding company or its subsidiary in the event of the involuntary unemployment of the debtor; or both: A commercial bank may be licensed to sell insurance or act as an insurance broker as provided in Section 12908 of the Financial Code. This section shall not apply to any bank or bank holding company which, under the authorization of the Federal Reserve Board, had prior to January 1, 1976, a subsidiary or affiliate licensed to sell insurance (except that subsequent authorization to expand such activities shall be subject to this section); or to any bank holding company owning a state-chartered bank which had, prior to January 1, 1976, a subsidiary or affiliate licensed to sell insurance: This section shall not apply to any person authorized or licensed to make loans pursuant to Division 2 (commencing with Section 18000); Division 9 (commencing with Section 20000); Division 10 (commencing with Section 24000); or Division 11 (commencing with Section 26000) of the Financial Code.

For the purposes of this section, the following definitions shall apply:

(4) "Bank" means any institution in this state defined in Section 108 of the Financial Code except that such term does not include a title insurance company authorized to transact a trust business under the provisions of Article 3 (commencing with Section 16000) of Chapter 3 of Part 6 of Division 8 or a trust company controlled by or under common control with a title insurance company;

(4) "Bank holding company" means the same as the definition of that term set forth in Section 8 of the Federal Bank Holding Company Act of 1956, as amended, but limited to holding companies which control a bank authorized to accept deposits in this state;

(4) "Subsidiary" means any corporation, association, or partnership, owned in whole or in part by a bank or bank holding company;

(4) "Affiliate" means any corporation, association, or partnership connected through the ownership of a 10 percent or greater interest by a common parent;

(4) "Credit life, health, and accident insurance" means insurance on the life and health of a borrower from a bank issued to secure the repayment of the amount borrowed;

(4) "Control" means the possession, by any means, of the power to direct or cause the direction of the management or activities of a licensed insurance agent or broker;

1850. The purpose of this chapter is to promote the public welfare by regulating insurance rates as herein provided to the end that they shall not be excessive, inadequate or unfairly discriminatory; to authorize the existence and operation of qualified rating organizations and advisory organizations and require that specified rating services of such rating organizations be generally available to all admitted insurers; and to authorize cooperation between insurers in rate making and other related matters.

It is the express intent of this chapter to permit and encourage competition between insurers on a sound financial basis and nothing in this chapter is intended to give the Commissioner power to fix and determine a rate level by classification or otherwise.

1850.1. In this chapter "rating organization" means every person; other than an admitted insurer, whether located within or outside this state, who has as his object or purpose the making of rates, rating plans or rating systems; two or more admitted insurers which act in concert for the purpose of making rates; rating plans or rating systems, and which do not operate within the specific authorized terms contained in Sections 1852.5, 1856.7, 1859.8, and Article 5 shall be deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.

1850.2. In this chapter "advisory organization" means every person; other than an admitted insurer, whether located within or outside this state, who prepares policy forms or makes underwriting rules incident to but not including the making of rates; rating plans or rating systems; or which collects and furnishes to admitted insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished from a rate making, capacity. No duly authorized attorney at law acting in the usual course of his profession shall be deemed to be an advisory organization.

1850.3. Unless otherwise apparent from the context, in this chapter

(4) "Member" means an insurer who participates in or is entitled to participate in the management of a rating, advisory or other organization;

(4) "Subscriber" means an insurer which is furnished at its request (4) with rates and rating manuals by a rating organization of which it is not a member, or (4) with advisory services by an advisory organization of which it is not a member. The following standards shall apply to the making and use of rates pertaining to all classes of insurance to which the provisions of this chapter are applicable:

(4) Rates shall not be excessive or inadequate; as herein defined, nor shall they be unfairly discriminatory;

No rate shall be held to be excessive unless (4) such rate is unreasonably high for the insurance provided and (4) a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable;

No rate shall be held to be inadequate unless (4) such rate is unreasonably low for the insurance provided and (4) the continued use of such rate endangers the solvency of the insurer using the same; or unless (4) such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using same has, or if continued will have, the effect of destroying competition or creating a monopoly;

(4) Consideration shall be given; to the extent applicable, to past and prospective loss experience within and outside this state; to configuration and catastrophe hazards; to a reasonable margin for underwriting profit and contingencies; to past and prospective expenses both countrywide and those specially applicable to this state; and to all other factors, including judgment factors; deemed relevant within and outside this state; and in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period for which such experience is available;

Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers;

(4) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of any such insurer or group with respect to any kind of insurance; or with respect to any subdivision or combination thereof;

(4) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions; or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, local conditions or dispersion of hazard; or any other reasonable considerations. Such classifications and modifications shall apply to all risks under the same or substantially the same circumstances or conditions;

1853. Subject to and in compliance with the provisions of this chapter authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurances; two or more insurers may act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond for rates; underwriting rules; surveys; inspections and investigations; the furnishing of loss or expense statistics or other information and data; or carrying on of research;

1853.6. Members and subscribers of rating or advisory organizations may use the rates, rating systems, underwriting rules or policy or bond forms of such organizations, either consistently or intermittently; but, except as provided in Sections 1852.5, 1859.8, and Article 5, shall not agree with each other or rating organizations or others to adhere thereto. The fact that two or more admitted insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization; or the underwriting rules or policy or bond forms prepared by a rating or advisory organization, shall not be sufficient in itself to support a finding that an agreement to so adhere exists; and may be used only for the purpose of supplementing or explaining direct evidence of the existence of any such agreement;

1853.7. Licensed rating organizations and admitted insurers are authorized to exchange information and experience data with rating organizations and insurers in this and other states and may consult with them with respect to rate-making and the application of rating systems;

1857.5. (4) The commissioner may promulgate reasonable rules and statistical plans; reasonably adapted to each of the rating systems in use within the state; which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience; in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him in determining whether rating systems comply with the standards set forth in this chapter. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a proving of countrywide expense experience; in promulgating such rules and plans, the commissioner may give due consideration to the rating systems in use and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system in use by it. The commissioner may designate one or more rating organizations or advisory organizations to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations.

(4) Reasonable rules and plans may be promulgated by the commissioners for the interchange of data necessary for the application of rating plans.

(4) In order to further uniform administration or rate regulatory laws, the commissioners and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to interchanging and the application of rating systems.

14800. The commissioner shall be appointed by the Governor, with the consent of the Senate and shall hold office for a term of four years, consecutive with the term of office of the Governor.

Article 2. Rating Organizations

1481. No rating organization shall conduct its operations in this state without first filing with the commissioner a written application for and securing a license to act as a rating organization. Any rating organization may make application for and obtain a license as a rating organization if it shall meet the requirements for license set forth in this chapter. Every such rating organization shall file with its application (a) a copy of its constitution, its articles of incorporation, agreement or association, and of its bylaws, rules and regulations governing the conduct of its business; all duly certified by the custodian of the original thereof; (b) a list of its members and subscribers; (c) the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served; and (d) a statement of its qualifications as a rating organization.

The fee for filing an application for license as a rating organization is one hundred seventy-five dollars (\$175) lawful money of the United States, payable in advance to the commissioner.

1482. To obtain and retain a license, a rating organization shall provide satisfactory evidence to the commissioner that it will:

(a) Permit any admitted insurer to become a member of or a subscriber to such rating organization at a reasonable cost and without discrimination, or withdraw therefrom.

(b) Neither have nor adopt any rule or exact any agreement, the effect of which would be to require any member or subscriber as a condition to membership or subscription, to adhere to its rules, rating plans, rating systems, underwriting rules, or policy or bond forms.

(c) Neither adopt any rule nor exact any agreement the effect of which would be to prohibit or regulate the payment of dividends, savings or unshared premium deposits allowed or returned by insurers to their policy holders, members or subscribers.

(d) Neither practice nor sanction any plan or act of boycott, coercion or intimidation.

(e) Neither enter into nor sanction any contract or act by which any person is restricted from lawfully engaging in the insurance business.

(f) Notify the commissioner promptly of every change in its constitution, its articles of incorporation, agreement or association, and of its bylaws, rules and regulations governing the conduct of its business; its list of members and subscribers; and the name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting such organization may be served.

(g) Comply with the provisions of Section 1487.

1484. The commissioner shall examine each application for license to act as a rating organization and the documents filed therewith and may make such further investigation of the applicant, its affairs and its proposed plan of business, as he deems desirable.

The commissioner shall issue the license applied for within 60 days of its filing with him if from such examination and investigation he is satisfied that:

(a) The business reputation of the applicant and its officers is good.

(b) The facilities of the applicant are adequate to enable it to furnish the services it proposes to furnish.

(c) The applicant and its proposed plan of operation conform to the required merits of this chapter.

Otherwise, but only after hearing upon notice, the commissioner shall in writing deny the application and notify the applicant of his decision and his reasons therefor.

The commissioner may grant an application in part only and issue a license to act as a rating organization for one or more of the classes of insurance or subdivisions thereof or class of risk or a part or combination thereof as are specified in the application if the applicant qualifies for only a portion of the classes applied for.

Licenses issued pursuant to this section shall remain in effect until revoked as provided in this chapter.

1484.5. Notwithstanding the provision of Section 1482.5, each rating organization possessing a license of indefinite term pursuant to such section shall owe and pay to the commissioner an annual fee of one hundred seventy-five dollars (\$175) in lawful money of the United States in advance on account of such license until its final termination. Such fee shall be for periods commencing on July 1, 1964, and on each July 1st thereafter and ending on June 30, 1965, and each June 30th thereafter, and shall be due and payable on March 1, 1964, and on each March 1st thereafter and shall be delinquent on April 1, 1964, and each April 1st thereafter.

1485. Subject to the approval of the commissioner, licensed rating organizations may make reasonable rules governing eligibility for membership.

1485.5. If two or more insurers having a common ownership or operating in this state under common management, are admitted for the classes or types of insurance for which a rating organization is licensed to make ratings, the rating organization may require as a condition to membership or subscription of one or more that all such insurers shall become members or subscribers.

1485.5. A workers' compensation insurance rating organization licensed pursuant to the provisions of Article 2 (commencing with Section 11750) of Chapter

2 of Part 3 of Division 2 which does not make rating, rating plans or rating systems for insurance covering the liability of employers for compensation or damages under the United States Longshoremen's and Harbor Workers' Compensation Act (20 U.S.C. 901, et seq.) shall not be required to be licensed as a rating organization or registered as an advisory organization pursuant to the provisions of this chapter and shall have authority under its license as a workers' compensation insurance rating organization to:

(a) Collect and tabulate loss and expense experience statistics and other information and data relating to insurance covering employers against their liability for compensation under the United States Longshoremen's and Harbor Workers' Compensation Act.

(b) Furnish or exchange such information and experience data to or with rating organizations, advisory organizations and insurers in this and other states.

(c) Adopt and enforce compliance by its insurer members with reasonable rules and statistical plans to be used in the recording and reporting by insurer members of their California longshoremen's and harbor workers' insurance loss and expense experience in order that such experience of all of its insurer members shall be available in such form and detail as will be of aid to the commissioner in the enforcement of and to its insurer members in complying with the provisions of this chapter.

(d) Engage in the same activities and carry out the same functions with respect to insurance covering the liability of employers for compensation or damages under the United States Longshoremen's and Harbor Workers' Compensation Act that it is authorized to engage in or carry out with respect to California workers' compensation insurance generally under the provisions of Article 2 (commencing with Section 11750) of Chapter 2 of Part 3 of Division 2 other than the making of rating, rating plans and rating systems.

Article 3. Unlawful Rebates, Profits, and Commissions

320. An insurer, insurance agent, broker, or solicitor, personally or by any other party, shall not offer or pay, directly or indirectly, as an inducement to insurance on any subject-matter in this state, any rebate of the whole or part of the premium payable on an insurance contract, or of the agent's or broker's commission thereon, and such rebate is an unlawful rebate.

320.5. The Legislature hereby finds and declares that the continued regulation of the business practices of insurers and their producers is in the interest of the citizens of the state and that the control and limitation of unlawful rebates, profits, and commissions is an essential component of that regulation which is necessary to effectuate an adequate and complete system and regulation of insurer and producer business practices.

The Legislature finds that the statutes controlling unlawful rebates, profits, and commissions continue to provide critical protection to insureds in this state from the numerous consequences that would occur in the absence of such regulation including company insolvency, unfair discrimination between insureds with identical risks creating subsidies from small purchasers of insurance in favor of large purchasers of insurance, decreased quality of services to insurance consumers, increased concentration of insurance distribution and sales mechanisms, and misrepresentation and unethical sales practices such as improper replacement or twisting to the detriment of the public.

It is the intent of the Legislature in enacting this section to clearly set forth the legislative intent supporting the enactment, continuing vitality, and importance of the unlawful rebates, profits, and commissions sections of this code.

321. An insurer, or an insurance agent, broker, or solicitor, personally or otherwise, shall not offer or pay, directly or indirectly, as an inducement to enter into an insurance contract, any valuable consideration which is not clearly specified, promised or provided for in the policy, or application for the insurance, and any such consideration not appearing in the policy is an unlawful rebate.

322. Any person named as the insured in any policy or named as the principal or obligee in any surety policy or the agent or representative of any such person who, directly or indirectly, knowingly accepts or receives any unlawful rebate is guilty of a misdemeanor.

323. (a) It is unlawful for any insurance agent or broker, or any insurance solicitor employed thereby, to receive any financial benefit from an automobile repair facility or any other form of direct or indirect consideration from any person for referring insureds to that person or that person's designee for vehicle repairs covered under automobile comprehensive coverage, property damage coverage, or automobile collision coverage of an insurance policy issued through the insurance agent or broker or by an insurer represented by the insurance agent.

(b) Subdivision (a) applies with respect to commercial and noncommercial policies of automobile insurance.

(c) For purposes of this section, "financial benefit" means the receiving of any commission or gratuity, discount on repair costs, free repairs, or employment by a repair facility.

324. Payments of commissions or fees by insurers or their agents to insurance brokers, when otherwise lawful under this code, are expressly authorized.

325. The paying or allowing of any commission or other valuable consideration on insurance business in this state to other than an admitted insurer or a licensed insurance agent, broker or solicitor is an unlawful rebate.

325.5. If at the time of the solicitation and issuance of a policy of life or disability insurance, or of a surety bond which by its terms continues until canceled, a person may lawfully receive commissions thereon, such person, or in the event of his death, his estate or heirs may continue to receive commissions thereon during the continuance in force or renewal of such policy or bond without being licensed under the provisions of Chapter 5, Part 3, Division 1 of this code, provided:

(a) Such recipient does not transact insurance in connection with such policy or bond while not so licensed; and

(b) The payment is made pursuant to a contract entered into, before such

solicitation and insurance; between the insurer paying or allowing the commission and such person.

324.5. It is unlawful for an insurance agent who is not also licensed as an insurance broker to receive commissions derived from insurance placed with an insurer which has not expected him to act as its agent in the transaction of such insurance.

It is unlawful for an insurance solicitor to receive commissions on insurance from any source other than the employer for whom he is licensed excepting on life or disability insurance transacted by him under individual licenses as life or disability agent issued to him pursuant to this code.

It is unlawful for any person to pay to an insurance agent or solicitor any commissions which he can not lawfully receive.

Except as provided in Section 325.2 it is unlawful for an insurer to receive for its own use commissions on insurance placed with another insurer.

324.6. Notwithstanding the provisions of Section 324.5, an insurer participating in any Assigned Risk Plan, as provided for in Article 4, commencing with Section 4480b, Chapter 1, Part 2, Division 8 of the Insurance Code, may pay to a licensed insurance agent and such agent may receive, a commission or consideration on any automobile or liability coverage written in addition to any commission or consideration required under such plan if such agent has been designated by the applicant for insurance as producer or record for the coverages required under such plan.

324.7. Any person, including but not limited to any person licensed, certified under this code or exempted under this code from regulation, who for consideration, addition, or agreed to advise, any person concerning insurance, insurance policies, insurance needs or insurance programs of any sort and who agrees to or does, allow credit against such consideration for such services for any portion of any insurance commission which may accrue directly or indirectly, to such person who so advises or agrees to advise, is guilty of making an unlawful rebate and guilty of a misdemeanor.

324.8. When the premium on a policy insuring an employer is based upon the amount or segregation of the employer's pay roll, and the employer, personally or knowingly through his employees, procures a lower premium by willfully misrepresenting the amount or segregation, such misrepresentation is an unlawful rebate as to the employees.

In addition to any penalty provided by law for unlawful rebates, the employer in such case is liable to the State in an amount ten times the difference between the lower premium paid and the premium properly payable. The commissioner shall collect the amount so payable and may bring a civil action in his name as commissioner to enforce collection unless the misrepresentation is made to and lower premium procured from the State Compensation Insurance Fund. In the latter case the liability to the State under this section shall be enforced in a civil action in the name of the State Compensation Insurance Fund and any amount so collected shall become a part of that fund.

324.9. When a statement of the amount or segregation of a pay roll is materially false, and an insurer, through a person employed by it in a managerial capacity, accepts the statement as the basis for the premium on a policy, the acceptance is an unlawful rebate if the accepting employee knows of the falsity.

324. Every insurer shall exercise reasonable diligence in securing the observance of this article by its agents:

324.1. It is unlawful for any insurer to appoint an agent for the purpose of enabling such agent, or the employer or person requesting the appointment of the agent, to obtain insurance at a cost less than that specified in the policy, or at a cost less than that specified in the application therefor.

324.2. As used in this section "personal or controlled insurance" means insurance covering an insurance agent, broker, or solicitor, or

(a) His spouse, his employer or his employer's spouse;

(b) Any person related to him or the persons mentioned in subdivision (a) within the second degree by blood or marriage;

(c) If the employer is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in such corporation.

(d) If his employer is a partnership or association, any person owning any interest in such partnership or association.

(e) If the agent or broker is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in the agent or broker and any corporation which is also similarly directly or indirectly controlled by the person who directly or indirectly controls the agent or broker.

(f) If the agent or broker is a corporation, any corporation making consolidated returns for United States income tax purposes with any corporation described in subdivision (c).

If premiums on personal or controlled insurance transacted by an insurance agent, broker, or solicitor payable in one year exceed the premiums on other insurance transacted by such licensee payable in the same year, the receipt of commissions upon the excess is an unlawful rebate.

Provided that during and after the sixth calendar year following the initial licensing of such agent, broker, or solicitor, in any manner as an agent, broker or solicitor, whether continuously licensed or not, if premiums on personal or controlled insurance transacted by him payable in any one such calendar year exceed 20% percent of the other premiums transacted by him payable in the same calendar year, the receipt of commissions upon the excess over such 20% percent is an unlawful rebate. For the purpose of this paragraph, if the agent or broker be an organization the sixth calendar year shall be the first calendar year beginning five years or more after the initial licensing of the organization, or any predecessor thereof, as an agent or broker.

Provided further, that this section does not apply to an individual licensee who (1) is licensed during all of such calendar year as a solicitor, or individually as an agent or broker, (2) during such calendar year conducts an individual business, not

being named to transact on any organization license nor owning any interest in any corporation or partnership transacting an insurance agency or brokerage business, (3) has been continuously licensed in some manner as an active agent, broker or solicitor for at least 55 years and (4) is at least 55 years of age at the beginning of the calendar year.

Whenever an officer or director of a corporation acts as agent, broker, or solicitor in the transaction of insurance covering the corporation, he shall be conclusively presumed to have received the full commission on such contract while an employee of the corporation. Whenever the remuneration for services of an employee is decreased by the employer or is made unreasonably small in amount but the employee is permitted, as an insurance agent, broker, or solicitor, to transact personal or controlled insurance, it shall be conclusively presumed that such employee received the full amount of commission on such personal or controlled insurance.

"Year" as used in this section means the calendar year. Suspension, revocation or denial of license for violation of this section may be ordered at any time within five years after the close of the year in which the violation occurred.

324.5. As used in this section "personal or controlled insurance" means insurance covering a life agent, or

(a) His spouse, his employer, his employer's spouse, or any group of employees under a group policy issued to his employer;

(b) Any person related to him, his spouse, his employer or his employer's spouse within the second degree by blood or marriage;

(c) If his employer is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in such corporation.

(d) If his employer is a partnership or association, any person owning any interest in such partnership or association.

(e) If the agent is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in the agent.

If commissions on personal or controlled insurance transacted by a life agent under his license as a life agent received in one year exceed the commissions received in that year on other insurance transacted by such licensee under his license as life agent, the receipt of commissions upon personal or controlled insurance in excess of those on such other insurance is an unlawful rebate.

Provided that during and after the sixth calendar year following the initial licensing of such life agent in any manner as a life agent, disability agent or life and disability agent, whether continuously licensed or not, if commissions on personal or controlled insurance transacted by him under any or all such licenses received in any such calendar year exceed 20% percent of the commissions received in the same calendar year on other insurance transacted by him under any or all such licenses, the receipt of commissions upon personal or controlled insurance in excess of 20% percent of those on such other insurance is an unlawful rebate. For the purposes of this paragraph, if the licensee be a joint firm licensee. The sixth calendar year as respects the firm shall be the first calendar year beginning five years or more after the initial licensing of the firm or any predecessor thereof as a joint firm licensee with any individual; the firm may be changed with a violation of this section separately based upon all joint firm licenses it may have held during the calendar year and an individual named on one or more joint firm licenses may be changed with a violation of this section separately, based upon all the licenses, individual and joint firm, he may have held during the calendar year.

Provided further, that this section does not apply to an individual licensee who (1) is licensed during all of such calendar year under one or more kinds of individual life licenses; (2) during all of such calendar year conducts an individual business, not being named in any joint firm license nor owning any interest in a corporation or partnership transacting business under any kind of life license; (3) has been continuously licensed in some manner as an active agent under some kind of life license for at least 55 years; and (4) is at least 55 years of age at the beginning of the calendar year.

"Year" as used in this section means the calendar year. Suspension, revocation or denial of license for violation of this section may be ordered at any time within five years after the close of the year in which the violation occurred.

324. Any insurer, insurance agent, broker, solicitor, or life agent and any officer or employee of an insurer, insurance agent, broker, or life agent that makes or receives an unlawful rebate is guilty of a misdemeanor.

324. The following acts are not unlawful rebates:

(a) The return by an insurer issuing policies on a participating plan, or any portion of the premium as a dividend after the expiration of the term covered by such policy;

(b) The payment of commission by any insurer or insurance agent, broker or solicitor, to another insurer, or insurance agent, broker or solicitor, upon insurance lawfully transacted in that capacity;

(c) The allowance by any marine insurer or marine insurance agent, broker or solicitor to any insured, of such usual discount as is sanctioned by custom among marine insurers as being additional to the agent's or broker's commission;

(d) The paying by an insurer to another insurer, or to an insurance agent, broker, or solicitor, of a commission in respect to a policy under which the payee is insured, or the receiving by such payee of such commission;

(e) The paying by an insurer of bonuses to policyholders on nonparticipating life insurance or otherwise about their premiums, in whole or in part, out of surplus accumulated from nonparticipating insurance;

(f) The return as a dividend by a life insurer of any portion of the premium on policies based on a participating plan at any time;

(g) The return by an insurer transacting individual insurance on a weekly payment plan, to policyholders who have made premium payments for a period of at least one year directly to the insurer at its home or district office, of a percentage of the premium which the insurer would have paid for the weekly collection of such premiums.

(h) The paying by any life insurer, or the receiving by life insurance policyholders of special compensations, or the allowing and receiving of credits already agreed upon in life insurance contracts now in force.

(i) The payment by an insurer of any portion of life insurance premiums payable by its employees pursuant to a life insurance program under which 75 percent or more of its employees are required to carry life insurance on their lives so long as they remain in the employment of insurer.

(j) The payment or allowance of a fee or commission by one surety insurer to another surety insurer in respect to a risk on which both are co-sureties.

763.5. The sale of the good will, business, list of policyholders or similar assets of an agent or broker in consideration of commissions or portions thereof to be thereafter earned by the use of such assets and payments of such consideration are not unlawful rebates if the purchaser is duly licensed to transact insurance and the receipt of the commissions would not constitute a violation of Section 760 if the person receiving them were licensed as an insurance agent.

764. Any person may be compelled to testify or produce evidence at the trial or hearing on a charge of violating a provision of this article, even though such testimony or evidence may incriminate him. A prosecution shall not be brought or maintained against such person for any act concerning which he thus testifies or produces evidence, except for perjury committed in so testifying.

765. If an insurer knowingly violates any provisions of this article, or knowingly permits any officer, agent, or employee so to do, the commissioner, after a hearing in accordance with the procedure provided in Section 704, may suspend the

insurer's certificate of authority to do the class of insurance in which the violation of this article occurred.

766. If an insurance agent, broker, or solicitor knowingly and wilfully violates any of the provisions of this article, the commissioner, after a hearing in accordance with the procedure provided in Article 13 of Chapter 5 of this part may suspend or revoke the violator's license.

767. Notwithstanding any provision in this article to the contrary, it shall not be unlawful for any licensed insurance broker to pay a commission to an agent or broker licensed under the laws of Mexico when such agent or broker in Mexico refers to the insurance broker licensed in this state a resident of Mexico who wishes to obtain a policy of automobile liability insurance to be effective in this state from an insurer licensed in this state, and such broker negotiates and effects such a policy of insurance for such resident of Mexico.

SECTION 8. Technical Matters

(a) This act shall be liberally construed and applied in order to fully promote its underlying purposes.

(b) The provisions of this act shall not be amended by the Legislature except to further its purposes by a statute passed in each house by roll call vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate.

(c) If any provision of this act or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Proposition 104: Analysis

Continued from page 102

- Permits, but does not require, insurance companies to offer an unspecified "good driver" discount.
- Enacts other insurance-related provisions, and reenacts many provisions related to various lines of insurance which are currently in law.
- Provides that if this measure receives a higher number of votes than other measures on this ballot, then those provisions in other measures that relate to the business of insurance shall have no effect.

No-Fault System

Starting July 1, 1989, this measure establishes a no-fault motor vehicle insurance system that (1) applies only to bodily injury and (2) permits individuals to sue for losses which exceed specified limits.

This measure applies to private and commercial motor vehicles including automobiles, trucks, buses and trailers. It does not apply to motorcycles and "off-road-type" vehicles which are not registered with the Department of Motor Vehicles.

This measure contains the following features.

1. "Basic" Benefits. Requires the following minimum basic benefits to be paid by insurance companies to injured persons regardless of who is at fault:

- Up to \$10,000 for medical expenses;
- Up to \$15,000 for lost wages; and
- \$5,000 for funeral benefits, in case the injuries result in death.

In general, the basic benefits would not be provided to an uninsured motorist, a person driving a stolen car, or a person engaged in the commission of a felony.

This measure provides that the basic benefits shall be available only to pay medical expenses and lost wages to the extent that these expenses are not covered by workers' compensation and disability benefits.

Any dispute concerning payment of basic benefits would be decided by arbitration, and not by court trial. The arbitration would be conducted in accordance with procedures established by the Insurance Commissioner.

2. Recovery of Workers' Compensation Costs. Restricts the ability of employers to be reimbursed for medical expenses and wage losses paid under workers' compensation and other similar programs when employees are injured in motor vehicle accidents. Currently, an

employer may recover the cost of benefits—such as workers' compensation—it provides to an employee who was injured in an accident by another person who was at fault.

3. Additional Recovery. Permits an injured person to recover costs in excess of the no-fault basic benefits by suing the party at fault for the accident.

4. Noneconomic Losses. Prohibits recovery for noneconomic losses (such as pain and suffering), except in cases involving (a) death or (b) serious and permanent disfigurement or injury. It would not limit the right to sue for damages in cases involving (a) the operation of an uninsured vehicle, (b) harm caused intentionally, or (c) specified crimes.

5. Attorney Fees. Limits plaintiffs' attorney contingency fees in motor vehicle accident cases involving bodily injury to the following: (a) 15 percent of the basic no-fault benefits recovered; (b) 33.3 percent of the first \$50,000 recovered over the basic benefits; (c) 25 percent of the second \$50,000 recovered over the basic benefits, and (d) 15 percent of the recovery over \$100,000.

6. Premium Reduction. Requires insurance companies to reduce—by 20 percent for a two-year period (July 1989 through June 1991)—their average statewide premium rates for specified types of motor vehicle insurance. This would include rates for basic bodily injury liability, uninsured motorist and basic no-fault benefits provided under this measure. This reduction does not apply to the personal property liability damage, collision and comprehensive portions of a motor vehicle insurance policy.

Other Insurance-Related Provisions

The measure enacts other motor vehicle insurance-related provisions including the following.

1. Claims Settlement Practices. Requires that disputes between an insurance company and persons other than policyholders be settled by arbitration rather than by court action.

2. Penalty. Increases the penalty from an "infraction" to a "misdemeanor" for second and subsequent convictions for violation of the current financial responsibility laws.

3. Insurance Fraud. Increases the authority of the Insurance Commissioner to investigate and prosecute insurance fraud.

4. Premium Discounts. Permits, but does not require,

MEMORANDUM

TO: Ginger Baim

FROM: David Rogers

RE: HB 166-Pros

DATE: April 27, 1989

1) Section 1: Overview

"Tort Reform" is a national issue born of widespread frustration with the civil justice system. Periodically, judicial and other public institutions must be reexamined and modified to help resolve problems and reflect contemporary thinking and experience. HB 166 represents one such attempt following the first incomplete effort at tort reform in 1986. When viewed objectively, the bill proposes reasonable measures which attempt to a) clarify and refine existing law; b) reduce the costs of litigation and other costs of doing business; c) reduce and restructure awards by matching losses with compensation and eliminating windfalls that are not needed to adequately compensate the victim; d) promote stability; and, in general, create a more equitable distribution of the costs and risks of injury. In so doing, the sponsors hope to improve our tort system and help bring about much needed relief for many professionals, businesses, non-profits and municipalities, urban and rural alike, who cannot afford and/or obtain adequate liability insurance as a result of the present situation. Not to forget the public who suffers when services are unavailable and/or more difficult to obtain because of insurance problems; who suffers because legitimate claims cannot be satisfied because there is no insurance, or not enough. The bill follows the example of at least one state which appears to have accomplished these goals following passage of similar legislation (and related court challenges). It was introduced out of a sincere desire to make the system effective, fair and predictable.

Critics of HB 166 (and similar measures) repeatedly argue that it will take away rights without even reducing rates. First, this bill is not just about insurance premiums. Each provision can be

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justified on the merits regardless of rate effects. Second, the sponsors agree there are no guarantees that rates will be reduced; but there is credible evidence that rates will, at a minimum, stabilize and possibly fall if the right mix of provisions is adopted and given time to work (See, for example, Milliman and Robertson, Inc. letter dated August 5, 1988; and information relating to California experience). As important, with the exception of the statute of repose which involves a delicate balancing of competing interests, no provision in this bill "takes away" the right to receive adequate and appropriate compensation; although it will reduce many awards. And while some tradeoffs are inevitable when you are trying to fix a problem of this magnitude and complexity, the sponsors feel a carefully crafted committee substitute can accommodate most of the significant concerns raised by victim rights advocates.

2) Sections 2-4: Statutes of Limitation/Repose

Statutes of limitation and repose are based on the premise that society as a whole cannot afford the price of lawsuits after a certain period of time. They are not designed to absolve defendants from any liability, but only to prevent them from having to defend an action brought many years after the acts in question have occurred; the so-called stale claim which often creates excessive problems of proof for defendants where documents are lost, witnesses have died or memories have faded, control has shifted to another party, standards have evolved and/or other circumstances have intervened. Given these considerations, it is simply not fair to subject possible defendants to the unreasonable risk of indefinite exposure to claims (including costly record keeping requirements), particularly when most actions can easily be brought within the proposed "window" periods, including those relating to minors and incompetents. Moreover, extended exposure to claims appears to result in significantly higher costs for "tail coverage" which force many of those affected to "go bare" and/or to withhold services. The public interest is not served in either case. Reasonable statutes of limitation/repose, which include appropriate exceptions, attempt to strike a difficult balance between competing interests - the interest of society in promoting a legal system which is fair to all parties, holds down costs and increases the possibility that services will be provided and victims will have a readily available source of money for compensation and the interests of society in protecting the relatively few victims who inevitably will be denied access to the courts under any repose system. An alternative solution, a reasonably priced "occurrence" policy, is not a realistic option at this

time. Please note that many states have adopted statutes of repose in various forms; many constitutional challenges to those laws have been unsuccessful (and the Alaska case is distinguishable). Finally, the sponsors doubt these provisions will encourage unprofessional conduct, as implied by critics.

3) Section 5 :

1986 legislation raised the standard of proof for punitive damages from a "preponderance of the evidence" to "clear and convincing evidence" but stopped short of defining what must be proved. The language proposed in HB 166 clarifies this ambiguity by restating the common law rule cited recently by the Alaska Supreme Court. (See *Tommy's Elbow Room, Inc. v. Kavorkian*, 727 P2d 1038 (Alaska 1986) at 1049)

4) Sections 6 and 7:

The law now specifies the crime committed by the would-be claimant must be a felony to preclude him or her from recovering damages. HB 166 logically expands this limitation to include misdemeanors which substantially contribute to the injury or death (but was not intended to cover minor prohibited conduct like jaywalking, joyriding or trespassing) and adds, in the interests of fairness, an exception which would prevent potential defendants from taking advantage of this shield if they too were engaged in committing a crime when the death or damages occurred. Any technical problems with this provision can be worked out.

5) Section 8:

Current law allows only the plaintiff to request periodic rather than lump-sum payments in connection with awards for future damages and makes no provision for determining attorney's fees in this instance. Since future damage awards compensate for loss of money which would have been received in the future, plaintiffs should not have an automatic "right" to receive that money now in one lump sum, if the award is otherwise adequate. In fact, society, which might otherwise get stuck with the tab, has an overriding interest in making sure that an award which is supposed to protect a person for a lifetime does just that. HB 166 therefore proposes to give either party the option to request periodic payments, but only with respect to that portion of a judgment relating to future damages. Since the court already has this authority, the so-called "mini-trial" concern expressed by critics is not a new issue. It should be noted that structured settlements are

not uncommon in Alaska, can have significant tax advantages for plaintiffs and are especially advantageous to "self-insured" municipalities and others with budget limitations. They do not "cheat" plaintiffs if properly established with strong companies by competent attorneys and/or judges on the basis of reasonable guidelines. Finally, in the interests of fairness and to prevent the possibility of attorney windfalls at the expense of plaintiff recoveries, this section clarifies that contingency fees be based on the present value of a settlement.

6) Section 9:

In the interests of fairness to plaintiffs, this provision was intended to amend existing law to require increases for anticipated inflation where periodic payments of future damages are ordered by the judge.

7) Section 10:

It is good public policy to protect volunteers from personal liability when acting within the scope of their official duties; although additional exceptions to this provision (e.g. auto accident situations) may be warranted. These organizations serve important public purposes and their vitality and effectiveness depends on the willingness of people from all walks of life to participate. Eliminating personal liability for acts or omissions which do not constitute gross negligence should help to encourage this kind of participation. It is important to keep in mind that a right of action against the entity itself is retained. Appropriate screening of applicants for these positions should take care of most concerns that immunity will foster sloppy decisionmaking.

8) Section 11:

Current law requires a deduction of certain collateral benefits from the judgement at defendants request. This determination is made after the trier of fact has established the amount of the award. To help minimize the impacts of prejudicial inferences concerning the plaintiffs financial circumstances, the jury should have all relevant information at its disposal before making a decision about the amount of a judgement including information regarding certain collateral benefits and any tax implications(or lack thereof)of an award of damages. The sponsors feel the jury can be trusted to be fair, particularly if this kind of information is evaluated in the context of appropriate jury instructions. Issues relating to offsets for plaintiff's out of pocket costs (e.g. insurance

premiums paid) and similar matters may warrant further consideration.

9) Section 12:

In the interests of fairness, this provision prevents plaintiffs from receiving a windfall since current rates for non-institutional investors (e.g. "T-Bills") are well below 10.5%. What a particular defendant can make on investments is irrelevant to the question of what is fair compensation to plaintiffs. "Offers of judgement" should be used to encourage settlements, not artificially high interest rate provisions.

10) Section 13:

Other than the fact that it is current practice, there is no good reason why plaintiffs should receive another windfall in the form of pre-judgment interest on damages relating to money not yet earned. Moreover, prejudgment interest requirements should not be evaluated on the basis of their settlement incentive value. Other provisions of the law are designed to serve that purpose.

11) Sections 14 and 15:

The bill's sponsors intended to limit this provision to pecuniary losses in situations where the decedent has no statutory dependents (spouse, children, other dependents). Current law already prevents recovery for non-pecuniary loss where there are no such dependents. HB 166 simply proposes to extend this principle to pecuniary loss since there is no compelling reason to award damages relating to economic loss to a successor in interest who did not rely on decedent for economic support. This amounts to economic waste which increases a defendant's financial obligations with no commensurate benefits to the public. Exceptions for medical or other expenses which must be paid by a relative or guardian may be warranted.

12) Section 16:

Primarily designed to protect potential defendants from nuisance suits, Rule 82 allows the court to award the cost of "reasonable" attorney's fees from the losing party to the winning one. The court decides what fee amount is appropriate on a case by case basis; if the plaintiff prevails, it's usually 10% of the award (ordinarily based on a fee schedule that is incorporated into the rule) and most often the fees are paid by the defendant or its insurer. If the defendant prevails there is no relative standard and,

typically, no insurance policy or "deep pocket" from which to collect. As a result, Rule 82 does little to deter frivolous suits and amounts to a "one sided" tax since victorious defendants rarely see this money. Alaska alone has such a rule; and speaking of mini-trials, Rule 82 is often the subject of litigation as to its applicability in a variety of situations.

13) Section 17:

A hospital's duty to provide certain services should not, by itself, be enough to find the hospital vicariously liable for the negligence of its non-employees; particularly since there is no reasonable way for a hospital to prevent an otherwise competent physician from committing malpractice. Please note that nothing in this provision removes the incentive to exercise care in the credentialing process or to maintain rigorous review procedures to insure standards. Any failure to exercise this care will still result in liability for the hospital. This section also is intended to create a "safe harbor" provision enabling hospitals that comply with appropriate notice requirements to avoid liability on a theory of ostensible, apparent or implied agency. It attempts to deal with two problems. First, some feel that hospitals should be vicariously liable for the negligence of independent contractor health providers because the public reasonably looks to the hospital (not the individual physicians) as the health care provider, and the hospitals do nothing to dispel this belief. Second, although hospitals may be held liable for the acts of independent contractor health providers on an implied agency theory upon a showing that the hospital "held itself out" as the employer of the provider, there are no guidelines to assist hospitals in determining what steps they might take to avoid this result. Section 17 attempts to solve both problems by permitting hospitals that wish to avoid vicarious liability on a "holding out" theory to give appropriate public notice, or fair warning, that the public must look to the provider, not the hospital, in the event of injury. And by spelling out the exact terms of this requirement, the hospital will know exactly what it takes to avoid liability on this theory.

While hospital's could require all doctors to carry insurance, this approach could lead to a loss of doctors at particular institutions and an increase of uninsured health facilities who can't afford to insure contractors who can't or won't insure themselves. In addition, the spectre of cross claims between the hospital and its doctors is an administrator's nightmare. Finally, since there is only one for-profit hospital in Alaska, the monopoly argument advanced

by critics is unpersuasive and does not take into account the fact that under Medicaid rules, hospital's cannot assume the liability for doctors and pass it through in the form of increased rates.

14) Sections 18 and 21:

These provisions are designed to increase our understanding of the current insurance crisis in Alaska by providing additional information and analysis regarding liability insurance issues including a review of the impact of "tort reform" measures on the availability and affordability of insurance. In response to comments that these studies should precede tort reform legislation, it is important to keep in mind that this is not a new issue. Alaska, like many other states, has been considering tort reform matters for a number of years. In fact, HB 166 is a response to our experience following passage of the 1986 package.

15) Section 19: This issue has already been addressed by the Committee.

16) Section 20:

a. Repeal of 9.17.010(c): The disfigurement and severe physical impairment exception has been characterized as an exception so large it swallows the rule. In practice, there are few cases to which the cap would apply unless these exceptions are deleted. Damages for non-economic loss (eg. pain and suffering, physical impairment, loss of consortium, disfigurement, and loss of enjoyment of life) are designed to give the victim some solace for her/his pain, emotional loss and inconvenience, and to make the negligent party acknowledge these effects through an additional monetary payment. It has always been recognized that the payment of money was both inadequate and imprecise; a measure of rough justice. While there is good reason to award such damages, according to a 1987 U.S. Attorney General's Tort Policy Working Group report, a primary cause of the current liability crisis is the increasing and unpredictable size of damage awards, especially those relating to non-economic damages, which in turn can be attributed to a relatively small percentage of all tort cases. This situation appears to encourage higher premiums to protect against the uncertainty. Further, according to the Working Group, disagreement over the value of pain and suffering awards coupled with the potential for an extremely high recovery for plaintiff is a major obstacle to out of court settlements. As the Working Group put it: "A limitation on damages is the single most important legislative reform of the tort law. Not only does it

significantly reduce costs of the tort system, but it also serves to expedite settlements....and mitigates the unfairness of the tort system for many plaintiffs and defendants arising from the fact that widely different damages often are awarded for nearly identical injuries...Ultimately, the question of whether non-economic damages should be limited or allowed to continue their rapid growth involves a balancing of conflicting societal interests, including society's interest in maintaining a stable and affordable tort system. This is a balance which State legislatures seem to be far more capable of striking than courts engaged in case-by-case adjudications." Note that a reasonable cap will have little or no effect on a majority of all tort cases. While it will reduce of size of some awards, the sponsors feel that such recoveries will still be appropriate by any reasonable standard.

b. This is an unnecessary provision. It is our understanding that competent defense attorneys are unlikely to agree to calculate damages under Beaulieu.

c. Bill's sponsors intended only to repeal the provision regarding periodic payments; not the subsection concerning collateral benefits in medical malpractice cases.

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ALASKA STATE LEGISLATURE

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SAM COTTEN
SPEAKER OF THE HOUSE

MEMORANDUM

TO: Liability Insurance Task Force

FROM: Speaker Sam Cotten, Chair

RE: Overview

DATE: September 15, 1989

I. INTRODUCTION AND OVERVIEW.

The Liability Insurance Task Force was established by the Alaska House of Representatives last session through House Resolution 10 (HR 10) in an effort to sort out the many controversies concerning "Tort Reform" and to "determine how the State may more effectively regulate insurance and provide civil justice"(see attached copy of HR 10). The task force consists of the chairs of the House Judiciary, Labor and Commerce and Health, Education and Social Services Committees and other members appointed by the Speaker of the House including public members "who are involved in tort reform issues or who are involved in insurance or civil justice".

The resolution notes in particular the problems faced in the public and private sectors as a result of rising insurance costs. It concludes that a comprehensive review of "statutes, case law, practices of the insurance and legal fields and the relationship between insurance costs and civil justice" is warranted under the circumstances and instructs the task force to "recommend to the legislature any changes to the statutes appropriate and necessary for reducing insurance costs and improving civil justice". A report of our findings and proposed legislation must be submitted to the legislature by January 31, 1990. The Task Force also terminates on that date.

As most of you already know, many of the issues we are obligated to address are highly controversial and have been on the table in one form or another for many years. The primary driving force behind creation of the task force was to obtain a "second opinion" from a balanced, independent source in a sincere effort to resolve, once and for all, these difficult questions to the greatest extent possible. Accordingly, I intend to be thorough, fair and objective; and hereby pledge that all interested parties will have their "day in court". I hope you share this view.

II. PRIOR LEGISLATIVE EFFORTS

The issue of skyrocketing insurance rates first surfaced in Alaska in the early 1970's. By 1975, the medical community concluded that legislative relief was required. A bill creating a Joint Underwriting Association passed the legislature during the 1975 session, but was vetoed by Governor Hammond who instead created the Governor's Medical Malpractice Commission to study the problem and make recommendations to the Legislature. (See attached). On the basis of this report and following extensive hearings on the matter, the Legislature enacted a comprehensive program which set up the basic medical malpractice claims system in operation today and which created the Medical Indemnity Corporation of Alaska, a primary medical malpractice insurer and required all Alaska doctors to participate as a condition of licensure. This latter provision was repealed in 1978 where participation was made voluntary.

There were no significant additional developments until 1986 when the Legislature passed "Tort Reform" legislation largely in response to the concerns of doctors and others who had organized into a broad based coalition. Conference CS for Senate Bill 377 (see attached) made a series of changes to our civil justice system including: Modified joint and several liability; Caps on non-economic damages (\$500,000 except damages relating to disfigurement or severe physical impairment); increased burden of proof for establishing punitive damages; limits on a persons's ability to recover damages for personal injury incurred while that person was committing a felony; detailed provisions on requirements for damage awards; limited liability for certain directors and officers of non-profit corporations, non-profit hospitals (including hospital citizen advisory boards) and members of school boards and school districts and members of governing bodies, commissions and citizen's advisory committees of a municipality; and provisions on contributory fault, collateral benefits, apportionment of damages, offers of judgment, costs and attorney's fees, including pre-judgment interest, and the effects of a release. This legislation has been characterized as a "patch-work quilt" of necessary compromises, and, in the

view of many tort reform advocates, did not go far enough toward making Alaska's civil justice system fair and predictable.

During the 1988 session, tort reform legislation intended to complete the 1986 effort was considered by the Legislature but significant differences between the House and Senate could not be resolved. The final Senate version of this bill (SCS HB 85) was substantially similar to HB 166 which will be discussed in detail below and is attached for your information.

And finally, the voters approved in November 1988 an initiative which eliminated joint liability for tort and other actions involving fault. A related provision limiting attorney contingency fees was disallowed by the Lieutenant Governor and is now the subject of litigation.

III. CURRENT SITUATION; SUMMARY OF PENDING LEGISLATION

Many Tort and Insurance reform proposals were discussed in great detail last legislative session, although most of the work was done in the House Labor and Commerce Committee chaired by Rep. Dave Donley, a member of this panel. Here is a brief summary of these measures in numerical order:

HB 166, by Cotten, Larson, Hoffman, Pettyjohn, Grussendorf, Foster, Collins and Boucher: An Act relating to civil actions; amending Alaska Rules of Civil Procedure 68 and 82; and providing for an effective date. CS for HB 166, by the House Labor and Commerce Committee: An Act relating to civil actions; amending Alaska Rule of Civil Procedure 68; and providing for an effective date.

HB 166 attempts to follow in the footsteps of its 1986 predecessor. In original form, it proposes significant changes to our civil justice system in an effort to a) clarify and refine existing law; b) reduce the costs of litigation and other costs of doing business in Alaska; c) reduce and restructure damage awards by matching losses with compensation and eliminating windfalls that the sponsor's feel are not needed to adequately compensate the victim d) promote stability; and in general, create a more equitable distribution of the costs and risks of injury. This controversial bill, similar to legislation passed in other states, is criticized primarily because it appears to limit the rights of victims without good cause. The bill: includes a six year statute of repose (i.e. absolute time limit starting from the date of injury) for bringing actions relating to personal injury, death or property damage; adds language which attempts to clarify the standard for punitive damages; limits a person's ability to recover for personal injuries or death occurring while that person was committing a crime; allows a defendant to request the court to order

periodic payments of damage awards(now only the plaintiff can make such a request); adds a requirement that periodic payment orders include increases for anticipated inflation; adds partial immunity for officers and directors of public corporations and electric or telephone cooperatives; rewrites the collateral benefits rule by allowing the jury to take into consideration certain other sources of compensation before making its damage determination; proposes a reduction of the interest rate on judgments and decrees from 10.5% to 8%; prohibits the current practice of allowing pre-judgment interest on future economic and noneconomic damages; requires attorney's to discount their fees to present value; establishes dollar limitations (caps) on certain awards; amends Alaska Rule of Civil Procedure 82 by prohibiting the application of Rule 82 attorney's fees in a civil action for personal injury, death or property damage unless allowed by statute or agreement of the parties; eliminates certain provisions regarding the computation of damages; limits civil liability of hospitals for nonemployees; and requires the state to provide to the legislature on a regular basis certain information and analysis regarding liability insurance issues including a review of the impact of "tort reform" on the availability and affordability of insurance.

CS for HB 166 is the result of several months of hearings in the House Labor and Commerce Committee. It makes several significant changes to the original bill including: revised "Findings and Purpose"; substantially revised statute of repose provisions; deletion of provisions in original bill concerning: limited liability for directors and officers of public corporations, Rule 82 attorney's fees, pre-judgment interest rates, damage caps, hospital immunity for the actions of non-employees, periodic payments, reductions of interest rates, discount of attorney fees to present value and punitive damages. The committee substitute also adds several reporting requirements, repeals AS 9.55.548 dealing with Medical Malpractice periodic payment and collateral sources rules, keeps provisions in the original bill which prohibit prejudgment interest on future damages not yet due at the time of trial, eliminates certain references regarding the computation of damages and completely rewrites the collateral benefits law but retains the opportunity to present evidence of collateral benefits to the jury prior to the award determination.

HB 333, by the House Labor and Commerce Committee: An Act relating to civil actions against insurers for unfair or deceptive acts.

This bill makes an insurer, who commits an unfair or deceptive act against an insured, liable for the actual damages resulting from the unfair or deceptive act.

HB 334, by the House Labor and Commerce Committee: An Act requiring certain persons who are in a regulated occupation or profession to obtain malpractice insurance.

Any regulated professional with a malpractice judgement entered against them would be required to obtain a malpractice insurance policy from a qualified insurer with coverage in an amount which is not less than \$100,000. This requirement would not apply to a person who is no longer employed in the occupation or profession that resulted in an award of civil damages, or to a regulated occupation or profession that is unrelated to the occupation or profession that resulted in an award of damages.

HB 335, by the House Labor and Commerce Committee: An Act amending Rule 68 of the Alaska Rules of Civil Procedure relating to the award of costs and attorney fees and to the payment of prejudgment interest.

This bill rewrites Rule 68 of the Alaska Rules of Civil Procedure by enhancing "offer of judgment" sanctions which are intended to provide incentives to settle litigation.

HB 336, by the House Labor and Commerce Committee: An Act relating to Medical malpractice advisory panels.

HB 336 would increase the size of Medical Malpractice Advisory panels from 3 to 5; limit the number of health care providers who serve on the panel to three members; and change the way the panel considers evidence.

HB 337, by the House Labor and Commerce Committee: An Act relating to malpractice insurance for health care providers.

Under this proposal, a malpractice insurance policy issued in Alaska to a health care provider would have to include coverage, as an insured under the policy, for any hospital at which the health care provider practices. The definition of "health care provider" includes: audiologists, chiropractors, dental hygienists, dentists, nurses, dispensing opticians, optometrists, physical and occupational therapists, physicians, podiatrists, psychologists and psychological associates.

HB 345, by the Rules Committee by request of the Governor: An Act Relating to medical malpractice and claims against health care providers and creating the Alaska Health Care Claims Board.

This bill, introduced by the Governor during the last days of the session, proposes a new way of handling medical malpractice claims. This is a significant piece of legislation which has not yet received much attention. The bill has three main components. It creates an Alaskan Health

Care Claims Board; specifies the procedures that the Board must use in deciding claims; and creates a no-fault system similar to Worker's Compensation. According to the Governor in his transmittal letter: "This bill simplifies the procedures that those injured by health care providers must go through to recover damages. The bill sets up a "no-fault" recovery system in an effort to reduce costs to both injured parties and health care providers. This proposed legislation is not perfect. It will need alot of analysis, public scrutiny, and careful drafting. Essentially it is a new concept which addresses a problem which affects all of us." For a more detailed review of this bill please see attached transmittal letter from the Governor dated May 5, 1989.

HB 449, by Donley and Gruenberg: An Act making a special appropriation to the Alaska medical malpractice matching fund for medical malpractice insurance premiums; and providing for an effective date. HB 450, by Donley and Gruenberg: An Act creating the Alaska medical malpractice matching fund; and providing for an effective date.

These bills propose a direct means of reducing certain medical malpractice insurance premiums by establishing a state assistance program for qualified applicants based on a statutory formula. The proposed initial appropriation to this fund is \$500,000 from unexpended and unobligated money that has been repaid to the medical malpractice liability revolving loan fund; the unexpended and unobligated balance of this appropriation would lapse and return to the general fund on July 1, 1995.

HB 355, by the House Labor and Commerce Committee: An Act relating to imposition of a uniform insurance premium tax; and providing for an effective date.

This bill proposes several changes to the laws concerning insurance premium taxes including the establishment of a uniform tax rate for all lines of insurance.

HCR 37, by the House Labor and Commerce Committee: Relating to the Alaska Bar Association.

This resolution urges the Alaska Bar Association: to develop an impaired Attorney program which will establish sanctions to encourage attorneys to practice competently; to hire an investigator to look into allegations of improper or incompetent practices; to require licensed attorneys to post the Association's disciplinary procedures in a prominent place in their law offices; to publish a list of disciplinary actions at least once per year and to stop the practice of keeping these matters private; and to review attorney fees and their relationship to the cost of liability insurance, to review the relationship between Rule 82 and contingency fees, to adopt standards for reasonable

contingency fees and to require disciplinary actions be taken against attorneys who exceed those standards.

IV. TASK FORCE STRATEGY/ORGANIZATIONAL PROPOSAL.

Immediately following our first organizational meeting, we will conduct an informal two-day workshop which will begin to focus on one or more of the following critical threshold questions: 1) Who is having insurance problems; and what are those problems?; 2) Litigation statistics and experience in Alaska; 3) How certain malpractice insurance rates are set by the insurance industry, including our own medical malpractice carrier, MICA; 4) The relationship between "tort reform" legislation (similar to that proposed in HB 166) and insurance rate setting including the experience in one or two other states; 5) The role of the State of Alaska in setting and monitoring insurance costs; 6) the extent to which professional competency is regulated in Alaska, with particular emphasis on doctors, lawyers, engineers and architects; 7) the pros and cons of adopting classic "tort reform" measures, regardless of their impact on insurance premiums; and 8) alternate systems for resolving tort claims. It is my hope that our ultimate efforts will be enhanced if we can develop, at the outset, a clearer understanding of these fundamental issues. A formal agenda for this first meeting will be sent to you as soon as possible.

If you have comments or questions please give me or Special Counsel David Rogers a call.

STEVE COWPER
GOVERNOR



STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

May 5, 1989

The Honorable Sam Cotten
Speaker of the House
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Mr. Speaker:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to medical malpractice and claims against health care providers. This bill simplifies the procedures that those injured by health care providers must go through to recover damages. The bill sets up a "no-fault" recovery system in an effort to reduce costs to both injured parties and health care providers.

This proposed legislation is not perfect. It will need a lot of analysis, public scrutiny, and careful drafting. Essentially it is a brand new concept which addresses a problem that affects all of us. I propose that the Legislature hold hearings and do the requisite research on this bill during the interim, so that we can make the necessary amendments and act expeditiously in the 1990 session.

The bill has three main components. First, the bill creates an Alaskan Health Care Claims Board. Next, the bill specifies the procedures that the board shall use in deciding claims. Finally, the bill changes the system of recovery to be one of no fault, paralleling the theory behind workers' compensation.

The Alaska Health Care Claims Board is made up of five members, three of whom are not, and have not been, connected with the legal or medical professions. The members are appointed by the governor. Board members serve staggered four-year terms and are compensated \$400 a day plus transportation and per diem. This amount will be necessary given the time commitment that is envisioned. The board has the power to adopt regulations, subpoena witnesses and information, and hold hearings concerning disputed claims. (The board may decide to hear nondisputed claims in certain circumstances). The Department of Commerce and Economic Development will employ the board's staff and provide general support for the board.

The board's rules are required to be as simple as possible, to encourage people to do their own claims rather than use outside counsel.

The bill sets out the procedure necessary to bring a claim to the Alaska Health Care Claims Board if the claim is denied by a health care provider. If the claim is accepted, the board reviews the claim to make certain that it is fair and complies with the provisions of the Act but, unless the agreement somehow violates the Act or is unfair, all agreements between parties must be accepted by the board. Since this is a no-fault system, it should be easier for parties to come to agreements, thus alleviating the great stress and cost of our current system.

If a claim is denied, the board may investigate the claim on its own. The board in its own discretion may order a hearing. If the board does so, the hearing must take place within 90 days after the order. If a party (the claimant, the health care provider, or some other third party whom the board finds to be "interested") requests a hearing, the board must hold a hearing within 90 days of the receipt of the request.

All interested parties are to receive 10 days' notice of a hearing, and, 30 days after the record closes, the board shall render its decision rejecting the claim or awarding compensation. Board orders must be easy to understand and must be supported by reasoned conclusions.

If the board orders compensation, it must comport with the compensation outlined in the bill. As previously mentioned, fault is not at issue in this decision. Because of this, there may not be compensation for pain and suffering or loss of enjoyment of life. In essence the bill establishes a "quid pro quo" not unlike that of the workers' compensation system. Although an injured person may not recover for pain and suffering or loss of enjoyment of life the person will recover for his other losses, and in a much speedier manner. Compensation may be had for medical expenses, treatment, and lost wages for existing employment at the time of injury.

To deal with cases of permanent impairment, the board must adopt a rating schedule for injuries (defining percentages of impairment) that is consistent with the American Medical Association Guides to the Evaluation of Permanent Impairment, supplemented from other recognized guides where the injury cannot be rated by the use of the American Medical Association Guide. The board shall make its awards to permanently impaired persons by using this rating system and multiplying the appropriate percentage of impairment by \$1,000,000.

In cases of nonpermanent injury, medical expenses are to be covered for a two-year period, or longer if the board determines it is necessary; and 100 percent of a person's wages are recoverable for the period the person cannot return to work.

Medical expenses are to be paid within 30 days after the date the expense is incurred. In cases of permanent impairment, compensation is to be paid in a lump sum, within 30 days after the date the board files the impairment rating. Lost wages are paid out on a weekly basis, as the loss is incurred. Lost wages are reduced by any temporary disability compensation payable under the Alaska's Workers' Compensation Act, the Federal Employees' Compensation Act, the Longshore and Harbor Workers' Compensation Act, or similar workers' compensation laws.

In cases where death results in an award, the award will not only include medical expenses and lost wages but also \$1,000,000 in compensation to the decedent's dependents. The statute sets out a schedule of how the award is to be distributed. All awards are subject to insurance subrogation and must be reduced by damages recovered through collateral sources.

In cases where there has been an "aggravated injury" caused by a health care provider's use of drugs or alcohol, or caused by a health care provider's deliberate and malicious act or conscious disregard and reckless indifference, penalties up to \$1,000,000 may be assessed against the health care provider.

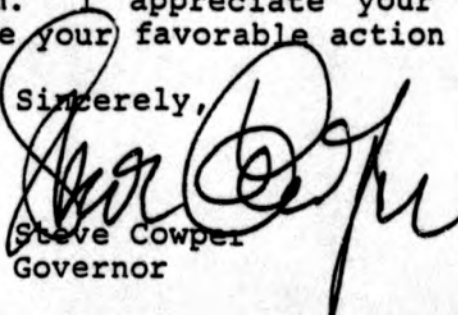
In all cases covered by the Act, compensation does not include pain and suffering or loss of enjoyment of life. This will reduce arguments over these subjects and clarify the liability to which health care providers are subject.

Final orders of the board may be appealed to the superior court. The superior court may review the final order as provided by the Alaska Administrative Procedure Act and the Alaska Appellate Rules.

This is a unique system and will provide the exclusive remedy that injured parties have against health care providers. However, in this era of rising insurance costs, when doctors have been forced out of business, something must be done to control the system of recovery. This bill is an attempt to come to a solution that will lessen the burden on both sides of a claim.

This bill is being introduced late in the legislative session, rather than waiting until next year, so that it may be studied over the interim. I appreciate your efforts concerning this topic and urge your favorable action on it.

Sincerely,



Steve Cowper
Governor

**Report of the Tort Policy Working Group
on the Causes, Extent and Policy
Implications of the Current Crisis in
Insurance Availability and Affordability**



February 1986

**The Citizens Coalition
For Tort Reform**

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INTRODUCTION
AND
EXECUTIVE SUMMARY

In October of last year the Attorney General established the Tort Policy Working Group, an inter-agency working group consisting of representatives of ten agencies and the White House. One of the tasks the Working Group was asked to undertake was to examine the rapidly expanding crisis in liability insurance availability and affordability.

The following is the report of the Tort Policy Working Group on the causes, extent and policy implications of this crisis. The primary contributing agencies included the Department of Justice, the Department of Commerce and the Small Business Administration.

Chapter 1 of the report (The Crisis in Insurance Availability and Affordability) describes in detail the significant problems many businesses, professionals and municipalities are having obtaining liability insurance. The Chapter documents a dramatic change in the last two years in the availability, affordability and adequacy of liability insurance. Where insurance is available (and in some areas it simply is not), premium increases of several hundred percent over the last year or two have become commonplace. Few if any private or public entities that rely on liability insurance have escaped the problems generated by this crisis.

Part A of Chapter 2 (The Causes of the Crisis in Insurance Availability and Affordability) reviews the current financial condition of the insurance industry, and the economic factors leading to that condition. The property-casualty industry in the past two years has suffered significant underwriting losses (\$21 billion in 1984; \$25 billion in 1985) which have limited its ability to offer as much insurance as its customers desire, and have made it reluctant to insure high risk activities which may expose it to further substantial underwriting losses. These underwriting losses appear to be largely a result of coverage written in the late 1970's and early 1980's which may have been underpriced due to the industry's desire to obtain premium income to invest at the then prevailing high interest rates.

Nonetheless, there is little to suggest that the recent massive increases in premiums is related solely to these losses, or that the cost of liability insurance will decline significantly as the industry limits its underwriting losses and restores its desired level of overall profitability. To the contrary,

indications are that developments in tort law are a major cause for the sharp premium increases. 1/

Part B of Chapter 2 reviews the contribution of tort law to the insurance availability/affordability crisis. The Working Group found that in the past decade there has been a veritable explosion of tort liability in the United States. Four specific problem areas are identified and discussed:

- ° The movement toward no-fault liability, which increasingly results in companies and individuals being found liable even in the absence of any wrongdoing on their part.
- ° The undermining of causation through a variety of questionable practices and doctrines which shift liability to "deep pocket" defendants even though they did not cause the underlying injury or had only a limited or tangential involvement.
- ° The explosive growth in the damages awarded in tort lawsuits, particularly with regard to non-economic awards such as pain and suffering or punitive damages. And,
- ° The excessive transaction costs of the tort system, in which virtually two-thirds of every dollar paid out through the system is lost to attorneys' fees and litigation expenses.

The Working Group was particularly struck by the extraordinary growth over the last decade of the number of tort lawsuits and the average award per lawsuit. A few examples amply illustrate this point:

- ° Between 1974 and 1985 there has been a 758% increase in the number of product liability lawsuits filed in federal district court.
- ° The number of medical malpractice lawsuits per 100 physicians doubled between 1979 and 1983, and tripled during that period for obstetricians/gynecologists.
- ° According to a jury verdict reporting service, between 1975 and 1985 the average medical malpractice jury

1/ The Working Group also considered whether state regulation of the insurance industry may be a cause of the crisis, and found little compelling evidence that state regulation is a major cause of these problems.

verdict increased from \$220,018 to \$1,017,716, and the average product liability jury verdict increased from \$393,580 to \$1,850,452. 2/

- ° A survey of punitive damage awards in Cook County, Illinois indicates that the average personal injury punitive damage award (measured in constant 1984 dollars) increased from \$40,000 in 1970-74 to \$1,152,174 in 1980-84.

The above data demonstrates that the insurance industry was selling coverage at constant or even reduced cost over a period of years during which tort liability was undergoing a dramatic expansion. This suggests that a major factor underlying the availability/affordability crisis is the industry's attempt to bring premiums quickly back into line with rapidly growing liability risks. 3/ The high -- and in some areas unaffordable -- insurance premiums reflect the fact that tort law is now placing a massive compensation burden on the private sector.

A second important contribution of tort liability to the availability/affordability crisis is the tremendous uncertainty that has been generated by rapidly changing standards of liability and causation. The "rules of the game" have become so unpredictable that the insurance industry often cannot assess liability risks with any degree of confidence. This appears to have severely exacerbated the problem.

Chapter 3 of the report (Recent Insurance Industry Developments) summarizes a number of responses of the insurance industry, its customers and state regulators to the crisis. These developments include the use of claims-made policies, the inclusion within policy limits of all or part of defense costs, the increasing use of self-insurance and captives, and more exacting state regulation.

In Chapter 4 of the report (Tort Law Reform) the Working Group concludes that while some of the above recent developments in the insurance industry, along with a likely improvement in the industry's financial condition, should relieve some of the current availability/affordability problems, it is unlikely that these changes will provide long-term, systemic relief without

2/ For purposes of comparison, the dollar lost approximately half of its purchasing power during this period.

3/ While some have suggested that the dramatic premium increases are an attempt by the industry to recoup its past underwriting losses, for the reasons discussed in the report such a theory makes little economic sense.

some fundamental reforms of tort law. Indeed, there are good reasons to believe that absent such reforms, particularly the insurance affordability problem will remain a long-term fixture of the American economy.

The Working Group recommends eight reforms of tort law that should significantly alleviate the crisis in insurance availability and affordability. The Working Group does not at this time recommend how these reforms should be implemented (whether at the federal or state level, or through legislative or judicial modification of the law); nor are these reforms meant to be an exhaustive list of potential reforms. The recommended reforms are:

- ° Return to a fault-based standard for liability.
- ° Base causation findings on credible scientific and medical evidence and opinions.
- ° Eliminate joint and several liability in cases where defendants have not acted in concert.
- ° Limit non-economic damages (such as pain and suffering, mental anguish, or punitive damages) to a fair and reasonable maximum dollar amount.
- ° Provide for periodic (instead of lump-sum) payments of damages for future medical care or lost income.
- ° Reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery.
- ° Limit attorneys' contingency fees to reasonable amounts on a "sliding scale."
- ° Encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

Chapter 5 of the report (Government Insurance: A Non-Solution) details the reasons why government insurance or indemnification would be highly undesirable and would do nothing to remedy the problems underlying the availability/affordability crisis. Such a federal insurance or indemnification program would not only be extremely expensive, but also could exacerbate the problems of tort law by making the "deep pocket" of the taxpayer available in many cases. In addition, such a program could undermine public health and safety, require more extensive government regulation of private sector activities, involve the government in substantial litigation, lead to increased federal involvement in state insurance regulation, and inhibit the ability of the private sector to adapt insurance services to changing economic and social conditions.

The Conclusion to the report lists five conclusions as to the appropriate response of the federal government to the current crisis in insurance availability and affordability. In sum, the Working Group concludes that while there are a number of factors underlying the insurance availability/affordability crisis, tort law is a major cause which the federal government can address in various sensible and appropriate ways. As for some of the other factors underlying the crisis, such as the insurance industry's recent large underwriting losses, there is little the federal government can or should do to remedy these problems.

In that both the tort liability and insurance developments in this report are highly dynamic, and because more detailed data and other studies undoubtedly will become available, the Working Group will continue to follow developments in this area, and, where appropriate, supplement its conclusions and recommendations.

Richard K. Willard
Chairman
Tort Policy Working Group

Robert L. Willmore
Chairman
Task Force on Liability
Insurance Availability

February, 1986

CHAPTER 1

THE CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY

Liability insurance is a linchpin in the operation of the United States economy, yet many American businesses, professionals and municipalities, both large and small, are encountering serious insurance problems arising from premium increases, policy cancellations and refusals to underwrite certain activities.

The liability insurance crisis has three separate but related faces that individually or in various combinations make it difficult for many entities to obtain the desired liability insurance. These problems are availability of insurance, affordability of insurance coverage and adequacy of coverage.

This Chapter describes the current nature and extent of these problems. The Chapter focuses, first, on the problems encountered within the various lines of insurance, and, second, on the effect of those problems on different sectors of the economy.

I. INSURANCE COVERAGE SUMMARIES

The following are insurance summaries taken predominantly from insurance industry reports prepared by the Alliance of American Insurers or published in Business Insurance.

Environmental Impairment Liability Insurance ("EIL")

EIL covers pollution incidents stemming from gradual pollution exposures (as opposed to "sudden and accidental" pollution, which traditionally has been covered under general liability coverage). Two major companies dropped out of the market in 1985, and by the end of the year only two companies were offering EIL coverage. Forty-seven companies were forced to close hazardous-waste management facilities for lack of EIL coverage. Most hazardous waste businesses currently are looking toward captives and self-insurance. Brokers expect significant price increases on the limited insurance still available.

Sudden and Accidental Pollution Coverage

Coverage for sudden and accidental pollution traditionally has been provided as part of general liability coverage. New general liability forms, however, specifically exclude all pollution liability. This is due to court decisions interpreting "sudden and accidental" coverage as also covering gradual and intentional pollution. (See Chapter 3 for a discussion of the new policy forms.) The London market currently is excluding pollution coverage from the large risks it insures.

Directors and Officers Liability ("D & O")

Premiums in 1985 rose 50% to 500%, and include larger deductibles, lower limits, more restrictive endorsements and shorter policy durations. Industries particularly affected include financial institutions, electric (nuclear) utilities, new high technology business, wildcat oil and gas companies, research and development enterprises, real estate developers, highly leveraged businesses, petrochemical companies and the steel industry. Capacity constrictions have hurt larger risks more than smaller risks. Traditional primary and reinsurance capacity has been reduced, but Lloyd's of London, which has in the past not been active in this line, is offering primary coverage up to \$20 million. Not surprisingly, business with Lloyd's of London is up to 100% to 200%. Much of the reinsurance market for such coverage has virtually dried up.

Bank Fidelity Bond Coverage

Premiums are up about 300%. A group of fifty banks are creating a mutual insurer to provide D & O and bankers blanket bond coverage.

Motor Carrier Liability Coverage

Bus and trucking companies are having severe difficulties obtaining the insurance coverage required by federal law. The Motor Carrier Act of 1980 requires insurance minimums of from \$750,000 for carriers of non-hazardous cargo to \$5 million for carriers of hazardous waste and most hazardous materials carried in bulk. The Bus Regulatory Reform Act of 1982 set insurance minimums from \$1.5 million to \$5 million, depending on the passenger capacity of the bus. Capacity is limited both in the primary and reinsurance markets. Small trucking firms and independent owner-operators have the most difficulty getting insurance.

Liquor Liability Coverage

Liquor liability coverage may be available as part of a commercial lines package, but is severely constrained and virtually nonexistent in some parts of the country as monoline coverage. This line has been affected by the bankruptcy of one of the largest dram shop insurers, Ideal Mutual Insurance Company.

Medical Malpractice Insurance

Availability problems are being encountered by nurse/midwives, obstetricians/gynecologists, pediatricians and dentists. Premiums are being raised and coverage limits are being reduced, sometimes by as much as 50%. Reinsurers are also restricting coverage in this line. St. Paul's Insurance Company, the largest medical malpractice insurer, has placed a moratorium on new policies. St. Paul's writes coverage for approximately 20%

of the Nation's doctors, and wrote an estimated \$600 million in malpractice business in 1985. It had a pure loss ratio (excluding loss adjustment expenses and operating expenses) of 81.3% in 1984. Doctor-owned mutual insurance companies account for more than half of the medical liability coverage in the country.

Commercial General Liability ("CGL")

Commercial general liability insurance has undergone significant premium increases. The Insurance Services Office ("ISO"), the property-casualty insurers' statistical and ratemaking organization, has filed a new CGL form which will limit coverage and which contains certain exclusions and policy limitations (see Chapter 3).

Excess Coverage

Excess coverage capacity has been sharply reduced. This coverage currently is offered primarily on a claims-made basis, which may or may not mesh with the primary, reinsurance and other excess layers.

Reinsurance

Reinsurance capacity for the United States market has been severely limited, particularly with regard to Lloyd's of London, which has faced both its own problems and a disillusionment with the American market. This capacity problem is expected to ease somewhat in 1986, but is likely to remain a problem for some time longer.

II. SECTORAL SUMMARIES

The following are summaries of the effect of the insurance availability/affordability crisis on various sectors of the United States economy. This information was obtained from surveys conducted by business groups, articles in the trade press and materials prepared by trade associations or provided by industry representatives. While the following does not include all of the available information, it summarizes the major findings.

Municipalities

Municipalities are among the hardest hit groups by both affordability and availability problems. Local officials preparing their budgets for the next fiscal year report that the market for public entities is "extremely limited" and "diminishing to nothing." Those cities able to secure bids are finding insurance companies' offers prohibitively expensive. Renewal rates have climbed by as much as 400% -- and often for lower coverages with higher deductibles. Some cities are facing premium increases of up to 1,000%.

The United States Conference of Mayors conducted a survey of 39 cities in the summer of 1985. Over half the cities were quoted premium increases of over 100%, and 16 were quoted increases greater than 200%. In addition, a recent report by the Wyatt Company, Public Officials Liability Insurance: Understanding the Market (1986), notes that local governments have reported premium increases of 200% to 300% in the insurance purchased for their officials.

Rather than renew, many cities have decided to "go bare." All cities have been forced to reevaluate and sometimes limit the services they provide their communities. Finally, in the wake of policy cancellations, a number of city and county officials have resigned, fearing personal exposure to lawsuits stemming from their official duties.

Transportation

The American Public Transit Association, the nation's largest organization of transit operators, reports that premiums for those companies able to obtain insurance this year have gone up 500% to 1,000%, and sometimes more. In Los Angeles, the Southern California Rapid Transit District's annual premium jumped from \$67,000 to \$1.7 million, while coverage was reduced. Transit problems were compounded by the bankruptcy of one of the largest companies involved in insuring mass transit systems. Some local transit systems have had to suspend operations.

Publishing

Newspaper and magazine publishers are finding it more difficult to obtain libel insurance.

Nurse-Midwives

The American College of Nurse-Midwives represents 2,500 members, 1,400 of whom were covered under a blanket policy through the association. The policy was cancelled on July 1, 1985. The association has been unable to obtain other coverage and has been attempting to create a captive insurer. The captive was to have started operation by April 1, 1986, but that deadline will not be met.

Grocers

A survey by the National Grocers Association found that its members' liability insurance premium rates had recently increased from 25% to 500%. The survey covered 161 retailers and 20 wholesalers.

Architects and Engineers

Most architectural and engineering firms, and particularly smaller firms, are experiencing severe availability and affordability problems. Insurance premium rate increases of

200% to 300% have become the norm. Roughly 30% to 40% of smaller firms are going bare. Engineering firms involved in asbestos or other toxic substances abatement activities face extreme difficulties in obtaining insurance, with rate increases, where insurance is available, of 5,000% not uncommon.

Day Care Centers

The National Association for Education of Young Children conducted a survey of day care providers. They covered family day care providers who care for children in a home setting, day care centers and headstart programs. The survey found that 40% of the respondents had had their insurance cancelled or not renewed and the majority of those with coverage had premium increases, most of which rose 200% to 300%.

Toy Manufacturers

The Toy Manufacturers of America recently surveyed its 243 members on insurance cost and availability problems. Final results will not be available until April, but initial responses are:

<u>Members</u>	<u>%Increase in premiums</u>
21	50
9	50-100
12	100-150
2	150-200
11	300-500
7	500-1000
1	over-1000
2	cannot obtain insurance

Companies that normally had three to four months to negotiate a policy renewal have been given only 72 hours to do so this year. This permits insufficient time for policy shopping. The association reports that it had recommended a captive to its members a few years ago. Commercial insurers reduced prices upon learning of the proposal, eliminating industry interest in a captive.

Household Appliance Manufacturers

The household appliance industry has seen sharp reductions in available coverage, and the Association of Home Appliance Manufacturers has lost group coverage it had arranged in 1983. Many companies have been able to obtain only about one-third of the coverage sought for product liability, and the cost of that coverage is increasing. Member companies are having similar problems obtaining D & O insurance.

Automobile Repair

The Automotive Services Councils, an association representing automobile repair shops and garages, conducted a survey with 104 responses. Average premium increases were 70% to 80%. Some 13% of the membership reported purchasing an average of 30% less coverage. Approximately 41% had experienced policy cancellations and 26% were unable to find new carriers.

Medical Equipment

The medical equipment industry has had a captive, MedMarc, an affiliate of the Health Industry Manufacturers Association, since 1979. The captive started with 35 companies and has recently reached 100 member companies. The rate of growth increased in 1985 as the result of cancellations by commercial insurers of about 20% of the Association's members and premium increases of five to ten-fold.

Biotechnology

Biotechnology companies are having a particularly difficult time in the tight market because they are generally new, small companies dealing mostly in research and development in a field largely unknown to insurers. Their inability to obtain coverage causes them difficulty in obtaining bank financing, which, in turn, causes some of these companies to sell out or forego promising research. The industry is exploring the creation of a captive.

Oil and Gas Drilling

The International Association of Drilling Contractors represents 1,500 contractors operating drilling rigs. It estimates maritime liability premium increases of 300% to 700% and inland liability premium increases of 100% to 150%.

Construction Contractors

Constructor magazine (October 1985) estimates average increases in general liability coverage of 40% to 75%. For contractors who were able to negotiate significant discounts in past years increases currently are running up to 300%. In 1985 premium increases for umbrella coverage were approximately 300% for less coverage.

Natural Gas Transportation

The National L-P Gas Association represents 4,100 firms that prepare and transport liquefied petroleum gases for residential and industrial users. According to a spokesman, as many as 25% of the transporters are operating with less than the \$5 million in insurance coverage that is required of motor carriers by federal law. Difficulties are attributed to unavailability and prohibitive costs of umbrella insurance.

General Manufacturing

The Machinery & Allied Products Institute ("MAPI") recently conducted a survey of 81 companies producing a broad range of products in the manufacturing industries and obtained an 80% response rate. The typical respondent experienced increases for every type of insurance covered in the survey. The survey covered general liability, D & O, environmental impairment liability, products and other property and casualty coverages. The size of the increases varied with the date of the renewal; consequently, the survey results understate the problem since many of the respondents are not up for renewal until early this year. Significant survey results are shown in the table below.

MAPI Survey Results on Liability Coverages

<u>Premiums</u>	<u>% Higher</u>	<u>% Change (Median)</u>
CGL-Primary	73	40
CGL-Excess	100	250
D & O	72	300
EIL	94	60
Products	95	116
Other	87	40
<u>Lower Limits</u>	<u>% Lower</u>	<u>% Change (Median)</u>
CGL-Primary	13	-36
CGL-Excess	66	-50
D & O	27	-25
EIL	59	-50
Products	33	-50
Other	18	-25
<u>Deductibles & Exclusions</u>	<u>% Higher Deductible</u>	<u>% More Exclusions</u>
GCL-Primary	34	97
GCL-Excess	25	96
D & O	49	95
EIL	50	89
Products	50	100
Other	28	100

In addition to the foregoing, 35% of the MAPI respondents indicated that their general liability coverage excluded "sudden and accidental" pollution coverage, while 49% indicated that it was excluded in some layers and included in others. Some 65% of the respondents indicated that they had some coverages cancelled since January 1, 1985.

Machine Tool Manufacturers

The National Machine Tool Association represents 300 to 400 businesses that manufacture heavy machinery which cuts, shapes and forms metal. Preliminary results of a survey indicated product liability premiums have doubled since 1984, and that about half of the respondents have been or expect to be put on claims-made policy forms.

Battery Recycling & Smelting Companies

Battery recycling companies are typical of many industries where processes create toxic wastes. Recycling 50 million scrap batteries accounts for up to 50% of the annual lead smelter production. If the batteries are not recycled, they will be disposed of in landfills, leading to more serious toxic exposure. One major smelting company was offered a \$10 million policy with a \$2.5 million deductible at a cost of \$650,000. While it deems the policy uneconomic, it has not found an alternative. The problem is widespread with smelters of various metals. The uncertainty of the risk and size of pollution liabilities has lead to substantial reductions in coverage with sharp increases in deductibles and premiums.

Power Equipment Manufacturers

Outdoor power equipment manufacturers had been reporting premium increases of from 50% to 70% during the past year. At the end of the year, with many renewals coming due, some have experienced increases of 400% to 600%. The Association once again is considering establishment of a captive.

General Aviation Manufacturers

The General Aviation Manufacturers Association reports that the cost of liability insurance per aircraft was \$51 for the 6,778 business, commuter and private aircraft delivered in 1962, and increased to \$211 for the 9,774 delivered in 1972. Currently, for the 2,000 planes delivered in 1985, the liability insurance cost has increased to \$70,000 per plane. The cost of liability insurance to air frame manufacturers in 1985 was about \$135 million, with a total cost of \$175 to \$200 million for the entire industry that includes manufacturers of engines, electronics and parts.

Ski Operators

Liability insurance premium increases of up to 400% have been reported by the National Ski Areas Association. Some small ski areas have closed, and the average price of lift tickets has increased substantially.

Aerospace Equipment Manufacturers

Aerospace equipment manufacturers are increasingly concerned that the escalating cost of product liability insurance and other associated costs are causing them to lose their ability to compete with overseas manufacturers of similar equipment.

III. THE NATURE AND EXTENT OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above examples of insurance availability, affordability and adequacy problems demonstrate the broad scope of the liability insurance crisis in the mid-1980's. In a similar crisis in the mid-1970's, the problem areas were largely confined to medical malpractice and product liability. Medical malpractice coverage has been a continuing problem, with almost half that coverage currently underwritten by doctors' and hospitals' mutuals and other alternative markets. Product liability coverage, however, was readily available at declining cost during the late 1970's and early 1980's.

A growing capacity shortage over the last year or more has caused commercial insurers to review carefully their underwriting standards and pricing policies in order to determine where insurance capacity can be utilized most profitably. The inevitable result of this reevaluation has been a severe disruption for insurance buyers.

Insurance Availability

Availability problems are occurring in certain specialty commercial insurance markets. These include pollution, day care, municipal, liquor, motor carrier and D & O liability coverages. The bankruptcies of some specialty insurers, particularly in the lines of motor carrier and liquor liability, have affected the capacity in these coverages.

In each of these lines, insurers have perceived the possibility of significant losses based on highly publicized verdicts and settlements. General line insurers who ordinarily would fill the gap left by specialty carriers are unwilling to do so because they can use their scarcer dollars in less volatile and more profitable lines.

Insurance Affordability

Premiums are increasing in virtually all commercial coverages. Examples of affordability problems include nurse-midwives and general aviation manufacturers, both of which face premium costs which may be warranted by the experience, but are too expensive for the buyers. Solutions to problems like these appear to lie outside of the insurance system.

Insurance Adequacy

Problems of insurance adequacy are being experienced across all commercial lines of coverage. The main problem seems to lie with the fact that many buyers are unable to buy as much

insurance as they desire. This is particularly true for large firms which seek large amounts of excess and higher limits coverage. These problems appear related in part to a capacity crunch created both by the insurance cycle and the withdrawal of capacity by the overseas reinsurers. The lack of capacity related to the insurance cycle shows signs of abating as the corner of the cycle has turned and surplus is increasing. But many firms may have to use alternative market mechanisms for at least a couple of years until this capacity fully returns. It may take much longer to get reentry by overseas reinsurers who have grave concerns about the American tort liability system. A second area of inadequacy lies in the growth of exclusions, deductibles and other policy limitations that are just now being introduced into the market. These are discussed in Chapter 3.

The Insurance Availability/Affordability Crisis

Finally, it should be noted that the crisis in insurance availability and affordability does not appear to be a crisis for the insurance industry. While the industry (as discussed in Chapter 2) is suffering substantial underwriting losses, the Working Group does not perceive this crisis to be a major threat to the financial viability of the industry. Rather, it is a crisis for the insureds who cannot obtain or afford the insurance they believe necessary for their on-going activities. And, to the extent that entities are forced to operate without insurance or with inadequate insurance, it is a crisis for victims of tortious conduct who may find that liable defendants cannot pay them their damages.

CHAPTER 2

THE CAUSES OF THE CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY

A number of reasons have been proffered for the crisis in the availability, affordability and adequacy of liability insurance. Many of these reasons relate to the economic decisions and performance of the insurance industry over the past decade. Other reasons focus on recent developments in tort law. While the two in fact are closely related, this Chapter discusses each of these areas separately. Part A deals with the general economic reasons for the current crisis; Part B reviews the contribution of tort law. 1/

1/ There have been suggestions that the availability/affordability crisis may be caused by certain aspects of state regulation. While some regulatory measures may have aggravated the problem, the Working Group has found little compelling evidence that the crisis is the result of a regulatory failure, either in the sense of insufficient or inadequate regulation, or in the sense of ill-conceived regulation. In this regard, it is worthwhile noting the 1977 report of the Department of Justice to the Task Group on Antitrust Immunities on The Pricing and Marketing of Insurance, which concluded that "in the commercial lines . . . state regulatory schemes are largely illusory and that insurers are generally free to set their own prices." Id., at vii. The report further indicated that rigid state rate regulation, such as is found in automobile insurance, may in fact aggravate an availability problem. Id., at vi.

In this regard, it is worth noting the conclusion of the Medical Malpractice Policy Guidebook (1985), prepared by Henry Manne (general editor) and Barry Anderson, Patricia Danzon, Clark Havighurst, Charles Phelps and Frank Sloan (principal authors) for the Florida Medical Association. The Guidebook concluded that it was difficult to fault the state insurance regulatory system for the high medical malpractice insurance premiums in Florida. Id., at 11. The report concluded that premium increases lag claims costs, and that "malpractice premiums are almost certainly not 'too high' compared to the increases in claims costs emerging over recent years." Id., at 149-50.

Some have pointed to state insurance reserve requirements as a cause of the insurance availability/affordability crisis, to the extent that they believe these requirements to have exacerbated capacity constraints. While the Working Group did not analyze whether state reserve requirements are too high or too low, it should be noted that these requirements exist to ensure the solvency of insurance carriers, and thereby to protect insureds. It also should be noted that the only way that state insurance reserve requirements conceivably could be modified to

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A.

I. INSURANCE INDUSTRY PERFORMANCE

Recent news accounts have presented a seemingly conflicting view of the economic performance of the property-casualty insurance industry. In order to understand the financial condition of the industry itself and of some of its specific lines of business, it is useful to compare the condition of the industry as a whole to what has been happening to premiums in the lines which present significant availability/affordability problems.

The table below presents premium and loss data for the property-casualty insurance industry for the period 1981 through 1985.

Year	Net Premiums Written (000)	Loss and LAE (000)	Expenses (000)	Statutory Under- writing Loss after Policyholder Dividends (000)
1981	\$ 98,805,725	\$75,764,229	\$27,132,052	\$- 6,323,534
1982	103,115,653	82,152,241	28,996,122	-10,415,751
1983	107,802,698	87,719,055	30,799,231	-13,285,049
1984	117,743,957	103,720,652	32,980,082	-21,455,300
1985*	142,300,000	126,840,220	37,353,750	-25,200,000

*Estimated

Source:

Best's Insurance
Management Reports

The most striking number in the table, of course, is the \$25 billion underwriting loss estimated for 1985. This number represents the difference between premiums written and expenses, policyholder

1/ (FOOTNOTE CONTINUED)

produce lower premiums would be if the reserve requirements were relaxed. It would be difficult to justify relaxing reserve requirements, however, in light of the fact that both insurance company insolvencies and the number of insurance companies reported to be in financial difficulty have increased substantially in the last two years.

The Working Group is continuing to review the contribution, if any, of state regulation to the insurance availability/affordability crisis.

dividends, 2/ estimated losses and loss adjustment expenses ("LAE").

The underwriting loss, however, while significant, represents only part of the industry's overall financial picture. Since premiums are collected well in advance of any anticipated payout, they are invested and earn income. In addition, other income is generated which also must be considered in reviewing the industry's financial condition. Overall income in 1985 resulted in the industry showing a \$7.6 billion gain in policyholders' surplus (the equivalent of net worth), 3/ on an underwriting loss of \$25.2 billion and net investment and other income of \$32.8 billion. Thus, the industry appears to have made an overall profit in 1985, though at a lower rate than historical levels or other sectors of the economy.

In discussing the overall financial review of the property/casualty industry, Best's reported that:

Investor interest in the property-casualty industry cannot be denied. While the Dow Industrial Average had made headlines by surpassing the 1500 mark (a 25% gain for the year), Best's Index of property/casualty companies has jumped 50% at this writing, and security analysts specializing in insurance--and cognizant of 1985's underwriting losses--nevertheless continue to be optimistic about the industry's prospects. 4/

Two factors must be taken into account in assessing the role of the insurance industry's financial performance in the insurance availability/affordability crisis. First, even though the industry currently is making a profit, that profit is well below the profitability of most other major industries, as well as the insurance industry's historical average. For example, in 1984 the property-casualty insurance industry produced an annual rate

2/ Questions have been raised as to whether or not the \$2.1 billion paid out in policyholder dividends should be included in the underwriting loss. Policyholder dividends are offered to some policyholders in some lines, and reduce the net cost of their insurance coverage. Consequently, any reduction in such premiums simply increases the net cost to policyholders.

3/ Policyholders' surplus is the difference between insurers' assets and liabilities. It is considered "the financial security that stands behind every insurance policy and is that which provides the cushion to support the shock of major catastrophe, stock market declines and loss of reserve inadequacies." ISO, Financial Condition of the Insurance Industry -- An Update (1985).

4/ Best's Insurance Management Reports (December 30, 1985).

of return on net income after taxes as a percent of net worth of 1.8%, whereas the median for Fortune 500 companies was 13.6%. 5/ The comparable rate of return for the property-casualty insurance industry from 1975 to 1984 was 10.9%. 6/

Second, the insurance availability/affordability crisis has not manifested itself across the entire spectrum of insurance services, but only in specific lines. These lines account for a relatively small portion of the industry. For example, the entire property-casualty insurance market accounts for only approximately one-third of the overall insurance market in terms of written premiums. 7/ The two property-casualty lines that have been the primary source of availability/affordability problems -- general commercial liability and medical malpractice -- amounted to only 7% of all the property-casualty lines in terms of 1984 written premiums. 8/ (These two lines thus represent approximately 2.5% of the entire industry's written premiums in 1984.) But, as can be seen in Subsection II, about one-fifth of the property-casualty industry's \$21.5 billion 1984 underwriting loss came from these two lines. And in 1985, the two lines accounted for almost one-quarter of the property-casualty industry's estimated \$25.2 billion underwriting loss. These two lines, as well as the Commercial Multiple Peril line, 9/ are discussed in greater detail in Subsection II.

II. UNDERWRITING RESULTS BY MAJOR LINES

While the industry overall has been profitable, certain lines have made major contributions to the underwriting losses. This section examines the major commercial lines in which availability and affordability problems have been most prominent.

Commercial Multiple Peril

Commercial Multiple Peril ("CMP") is related to the general liability line of insurance in that it is a packaged line of business which includes some commercial general liability coverage and its long-tail losses; that is, losses which may be

5/ Insurance Information Institute, 1985-86 Property/Casualty Factbook, page 22.

6/ Id. The comparable statutory accounting rate of return was 11.9%. Id.

7/ Congressional Quarterly Weekly Report, page 150 (January 25, 1986).

8/ Insurance Information Institute, 1985-86 Property/Casualty Factbook, page 16.

9/ If the Commercial Multiple Peril line is taken into account, approximately 14% of the property-casualty industry (in terms of 1984 written premiums) accounted for about one-third of its underwriting losses in both 1984 and 1985. Id.

reported many years after the policy year. CMP experience over the past five years is reflected in the chart below.

Commercial Multiple Peril

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Under- writing Expenses (Billions)	Statutory Under- Writing Loss After Policyholder Dividends (Billions)
1981	\$6.8	\$4.6	\$2.5	\$-0.5
1982	6.9	5.3	2.7	-1.2
1983	7.2	5.9	2.9	-1.7
1984	8.2	7.9	3.2	-2.9
1985*	11.7	10.4	4.1	-3.0

*Estimated

Source: Best's Insurance Management
Reports 12/30/85

While the underwriting losses for CMP rose to \$3 billion in 1985, it is readily apparent that until recently there had been little premium growth in the line. Best's predicts that the short-tail, non-liability portion of CMP should provide the ability for a fast turnaround for this line. It also notes that ISO's new CGL claims-made form will be added to the standard CMP form, but that market pressures should assure the availability and affordability of the smaller businessowner's package. 10/

Commercial General Liability

Commercial General Liability ("CGL") coverage includes most of the commercial sectors which are experiencing serious availability/affordability problems. It covers product liability, municipalities, day care centers and other commercial coverages. It is the line for which ISO has introduced its new claims-made form. The experience of this line over the past five years is summarized below.

General Liability

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Under- writing Expenses (Billions)	Statutory Under- Writing Loss After Policyholder Dividends (Billions)
1981	\$6.0	\$5.1	\$1.8	\$-1.0
1982	5.6	5.4	1.8	-1.7
1983	5.7	6.0	1.8	-2.1
1984	6.5	7.8	1.9	-3.2
1985*	11.1	13.2	2.7	-4.6

*Estimated

Source: Best's Insurance
Management Report

10 Best's Insurance Management Reports (December 30, 1985).

As is apparent, written premiums dropped in 1982 and 1983 and rose slightly in 1984. The figures for 1985, however, show a dramatic increase of 72% over the 1984 premium. Increases are continuing to occur in the line as policies come up for renewal. Losses increased throughout the period, but did so at a relatively even pace until 1984, when losses increased by over \$1 billion dollars over the previous year's losses.

Medical Malpractice

Medical malpractice represents only about 1.8% of property/casualty insurance written, but has been the source of major availability/affordability problems. The following chart summarizes the experience of the line over the past five years.

Medical Malpractice				
Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Under- writing Expenses (Billions)	Statutory Under- writing Loss After Policyholder Dividends (Billions)
1981	\$1.3	\$1.6	\$0.2	\$-0.5
1982	1.5	2.0	0.2	-0.7
1983	1.6	2.1	0.2	-0.8
1984	1.8	2.8	0.3	-1.1
1985*	2.6	3.6	0.3	-1.4

*Estimated

Source: Best's Insurance
Management Report

Medical malpractice experience is receiving considerable attention at the state level. Unlike many lines of coverage such as product liability, rates are based on state claims rather than national data.

III. PREMIUM TRENDS

The recent rapid growth in premiums has been a major element in the current availability/affordability crisis. This section examines this trend. The following data was provided by the ISO.

Cash-flow underwriting is generally acknowledged to have played a role in causing the large underwriting losses presently being experienced in the commercial lines. According to ISO, the industry's current underwriting losses are a result of "a

prolonged period of underpricing and rapidly expanding tort liabilities." 11/ In this regard, the ISO report states:

For the better part of seven years, the insurance industry has been engaged in a brutal price war. During the early 1980's, the price for commercial insurance was decreasing, sometimes sharply, as insurers vied for premium dollars to invest at the high interest rates then in effect. At the time, commercial customers did not complain. Indeed, many realized that commercial insurance in the United States was being sold below cost, even when investment income was considered. 12/

Chart A, based on ISO data, tracks commercial line premiums in constant 1967 dollars. As can be noted from the chart, 1984 marked the first real increase in premiums (in constant dollars) after five consecutive years of declining written premiums. But 1984 written premiums were almost 20% less than premiums collected in 1978, the year preceding the dramatic decline in premiums. At the same time, losses and expenses in 1984 were at an all-time high. 13/

A similar comparison of the general liability premiums written, premiums earned and line outgo over the past ten years (not in constant dollars) is shown in Chart B.

Analyzing this data, the Best's report notes that during the relevant period (1975 - 1985):

. . . the inflation of liability awards could have been no secret to any underwriter. Had the ascending line of premiums written that was established in 1975 through 1978 continued to rise, the general liability losses of \$13 billion incurred in the last six years largely would have been avoided. 14/

11/ ISO, Financial Condition of the Insurance Industry -- An Update (1985).

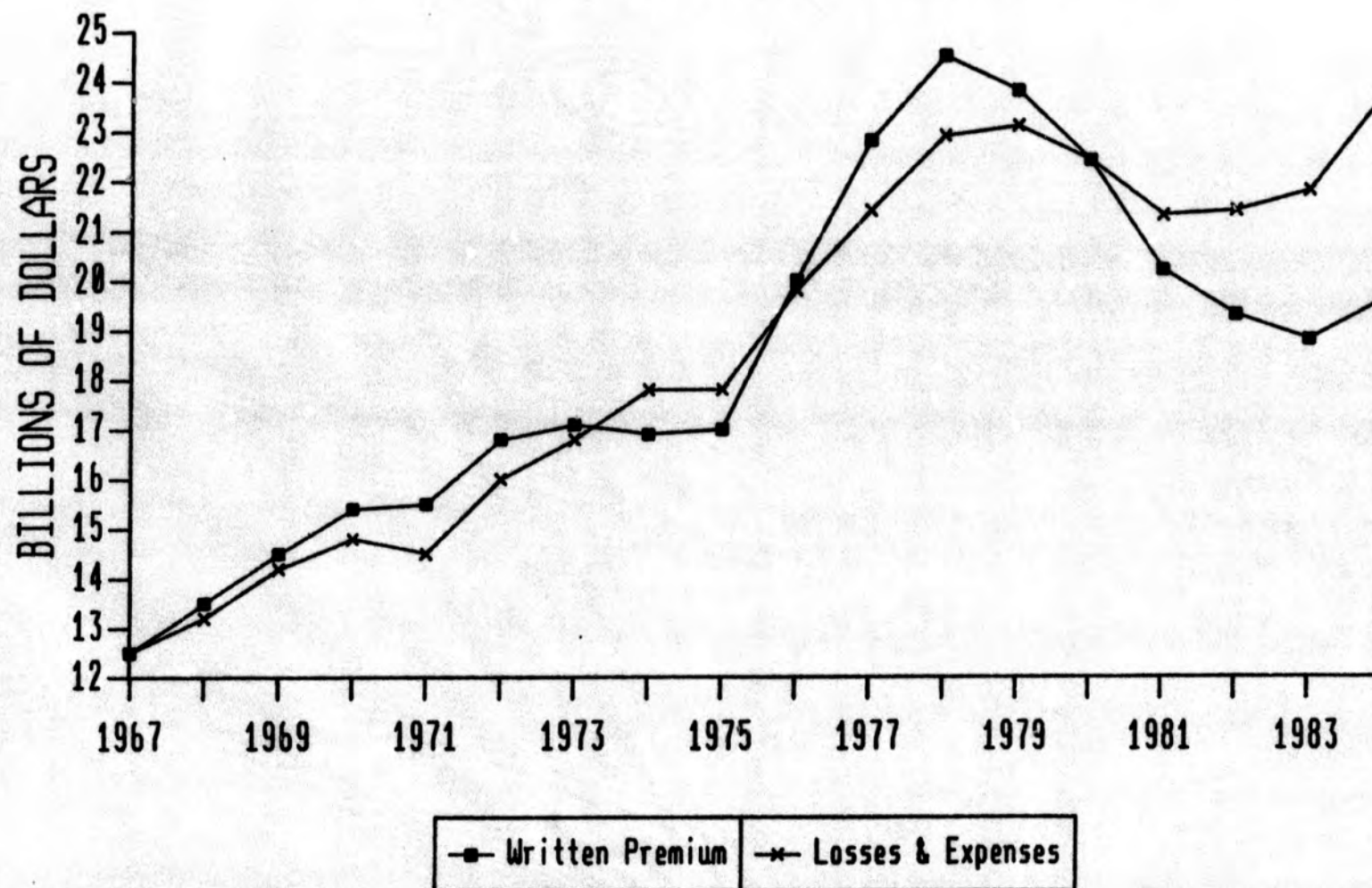
12/ Id.

13/ Id.

14/ Best's Insurance Management Reports (December 30, 1985).

CHART A

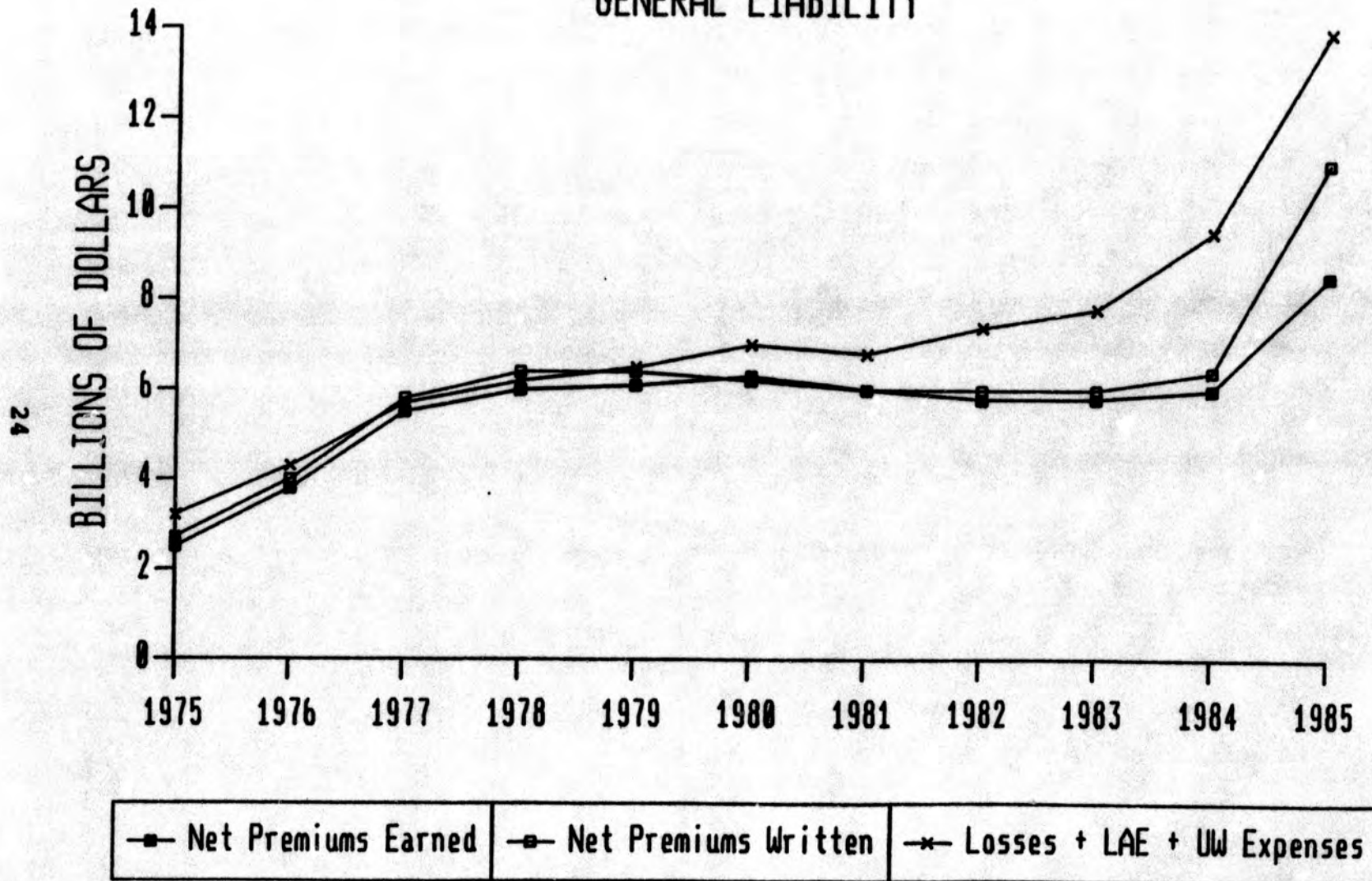
WRITTEN PREMIUM vs. LOSSES & EXPENSES COMMERCIAL LINES IN CONSTANT 1967 DOLLARS



Source: Insurance Services Office

CHART B

GENERAL LIABILITY



Source: Best's Insurance Management Report, 12/30/85

IV. THE ECONOMIC CAUSES OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above discussion indicates that during the late 1970's and early 1980's the insurance industry engaged in significant premium reductions while claim losses increased steadily. The result, not surprisingly, has been massive underwriting losses in recent years.

It is useful in considering the contribution of such economic factors to the insurance availability/affordability crisis to distinguish two different effects which frequently are confused. The first is the inflationary effect on premiums of the recent decline in interest rates. The second is the premium cutting which took place in the late 1970's and early 1980's as a consequence of the industry's desire to take advantage of high interest rates available during that period.

As to the first effect, there is an obvious inverse relationship between premiums and the prevailing interest rate. A significant portion of an insurer's profits stem from the return on the premium income it invests between receipt of the premium and payout of the incurred liabilities. When interest rates are high, premiums tend to be lower since more of the insurer's income comes from such return on investment; and when interest rates are low, premiums will tend to be higher since the insurer is more dependent on the premium principal to cover the anticipated payout. Thus, as interest rates fall -- as they have in the mid-1980's -- insurance premiums inevitably increase.

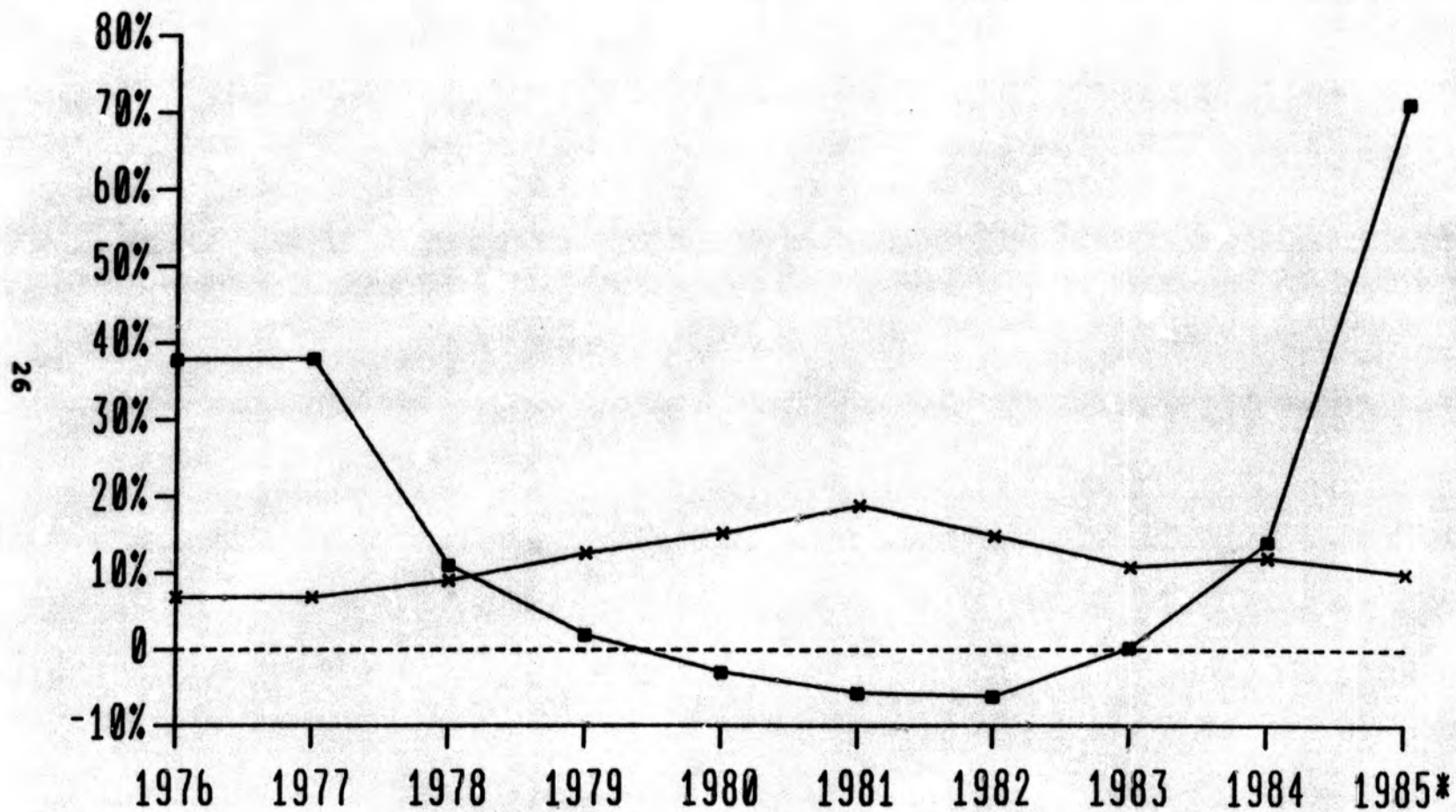
This inverse relationship is illustrated by Chart C, which compares the prime rate in 1976 through 1985 to the annual percentage change of the total Commercial General Liability (CGL) premiums written by the insurance industry in each of those years. ^{15/} Chart C graphically demonstrates that the rate of growth of the written premiums changes inversely with the movement of the prime interest rate.

To the extent that the recent sharp premium increases are related to the drop in interest rates, there is little the federal (or any) government can or should do to mitigate this market effect. Declining interest rates cause innumerable economic realignments which, on the whole, are quite beneficial to the economy. An increase in insurance premiums resulting from such a reduction in interest rates, while of itself undesirable, is a relatively minor side effect to the far more significant economic consequences of a drop in the interest rate.

^{15/} The percentage change in 1976 through 1984 is obtained from the Insurance Information Institute's most recent Property/Casualty Factbook. The estimate for 1985 is obtained from the ISO data discussed supra.

CHART C

PERCENTAGE CHANGE IN GCL PREMIUMS COMPARED TO INTEREST RATE



* PRIME INTEREST RATE	* ANNUAL % CHANGE IN WRITTEN GENERAL LIABILITY PREMIUMS
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*1985 Data Estimated

Moreover, there is little that can be done to address this source of premium volatility. It would be absurd to try to keep interest rates high simply to keep insurance premiums as low as possible. But as long as interest rates fluctuate, premiums necessarily will reflect such changes.

A second economic factor related to interest rates is the extent to which high interest rates may have triggered "excessive competition" in the insurance industry which led the industry to sell its product too cheaply. For one thing, even assuming one accepts the concept of "excessive competition," it is unclear how such losses in fact contribute to the insurance availability/affordability crisis. As discussed later in this Chapter, such losses are "sunk costs" which the industry cannot recoup simply by charging higher premiums. If premiums in fact are higher than the insured risks and the currently available investment return dictate, either other sources of capital (including insurers who have suffered no losses or lower losses) should offer the same insurance at a lower price, or insureds will retain these "excess profits" for themselves through self-insurance or the formation of captives. The fact that there appears to be little insurance coverage being made available by new or expanding underwriters, and that many insureds are highly reluctant to self insure or form captives (even though many with serious availability problems may have no alternative), strongly indicates that recoupment of losses is not a particularly compelling explanation for the current insurance availability/affordability crisis.

It is particularly puzzling that the proponents of this theory advocate the abolition of the insurance industry's antitrust immunity contained in the McCarran-Ferguson Act (Public Law 79-15) as an appropriate response to the asserted problem of the industry's cash-flow "mismanagement." It is hard to reconcile the argument that the current problems of the insurance industry stem from "excessive competition" with the proffered solution of removing the industry's antitrust immunity. Since the goal of antitrust law is to enhance competition, if one truly believes that the problems of the insurance industry are a result of too much competition, the last thing one would advocate is a legal change which would increase the level of competition. While the Working Group did not review and takes no position on the continuing validity of the industry's antitrust immunity, 16/ it is readily obvious that the suggestion that allegedly "excessive competition" can be cured by even more competition is patently absurd.

16/ Despite the assertions of some, the Working Group found no evidence to suggest that the industry's antitrust immunity is a significant factor in the insurance availability/affordability crisis. It should be noted, however, that the immunity has been criticized for a variety of other reasons. See the 1977 report of the Task Force on Antitrust Immunities, footnote 1, supra.

The reasons why the loss recoupment (or excessive pricing) theories advocated by some make little economic sense can briefly be summarized as follows:

- ° Insurers, like all profit maximizing companies, charge the price which maximizes their profits. Past gains or past losses are irrelevant to setting the price today which will maximize profits tomorrow. The argument that insurers are charging higher premiums to recoup past losses suggests that absent such losses their premiums would be lower -- that is, that they would not be charging premiums that maximize their profits. That makes little sense.
- ° Even if excessive premiums were being charged by some insurers to recoup their past losses, for the reasons discussed, other insurers would offer the same coverage at lower prices reflecting the actual risk, or insureds would retain such excess profits for themselves through self-insurance or the formation of captives. 17/
- ° The commercial lines of insurance, which are at the center of the availability/affordability crisis, in fact are relatively competitive. For example, the 1977 report of the Task Force on Antitrust Immunities (see footnote 1, supra) found that the property-liability insurance industry "appears to possess an atomistic market structure," including over 900 companies. Id., at 7. 18/ The Task Force also found that the restrictions to entry do not appear significant in the property-liability insurance industry, id., at 9, and that there appears to be price competition in this line as a result of "an industry structure that favors competition." Id., at 27-28. 19/ It is, of course,

17/ Many insurance companies are mutuals, meaning that they are owned by their policyholders. The suggestion that they are charging their policyholder-owners unnecessarily high premiums makes even less sense, since any such excess profits must be rebated through policyholder dividends.

18/ The report states that 20 insurance groups account for 53% of written premiums, and that no single group accounts for a major share of the market. Id., at 8. This is consistent with the analysis of the Medical Malpractice Policy Guidebook (H. Manne, 1985), which found the medical malpractice insurance market in Florida to be "substantially and effectively competitive." Id., at 166.

19/ See also page 348 of the report summarizing the Task Force's
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difficult to conceive how premiums are being kept at artificially high levels for a line of insurance in which prices appear to be competitively determined.

- ° Finally, many of the strongest proponents of the loss recoupment theory also contend that these losses were the result of excessive price competition in the industry. Obviously, it is difficult to reconcile these arguments. 20/

In sum, to the extent that purely economic factors underlie the insurance availability/ affordability crisis, they do not appear to be the type of problems which can be cured by different or more intensive forms of government regulation -- either at the state or federal level -- of the insurance industry. There, however, is a cause of the availability/ affordability crisis at the very heart of that crisis which the government is well placed to address in a variety of constructive ways. That cause is tort law, and its role in the crisis is discussed in Part B of this Chapter.

B.

The above discussion has focused largely on the current financial condition of the insurance industry, and the economic factors leading to that condition. The following discussion examines the state of tort law, and its central role in the insurance availability/affordability crisis.

Unlike the above related economic data on the insurance industry, it is difficult to obtain good empirical data indicating precisely what has happened to tort liability in

19/ (FOOTNOTE CONTINUED)

conclusion that the "industry is structured in a manner conducive to competition." It should be noted that these conclusions did not appear to apply to some other lines of insurance such as life insurance.

20/ These same points apply equally well to arguments that premiums are set excessively high to recoup losses resulting from mismanaged investment portfolios. Just as past losses are irrelevant to determining the premiums which will maximize profits, investment portfolio losses should have no bearing on premiums. In this regard, however, it should be noted that the property-casualty industry made \$32.8 billion from net investment and other income in 1985. See supra.

recent years. 21/ It is plain even to the most uninitiated that tort law has changed dramatically in recent years -- from a relatively quiescent legal backwater into one of the most important and dynamic areas of the law today. 22/ Moreover, a growing body of case examples and empirical data suggest that the current tort system has serious problems and is operating quite poorly. The insurance availability/affordability crisis is one symptom -- albeit the most dramatic and acute symptom -- of the dislocations and problems generated by a malfunctioning tort system.

I. PROBLEM AREAS IN TORT LAW

In attempting to understand what has happened to tort liability in the United States, the Working Group has focused on four interrelated areas: fault, causation, damages and transaction costs. Each is discussed separately below.

The Movement Toward No-Fault Liability

One of the most disturbing aspects of the current tort system is the degree to which it has moved toward no-fault liability. While this movement began in earnest over twenty years ago, it appears to have accelerated dramatically in recent years.

Beginning in the early to mid-1960's it became fashionable to reject the twin pillars upon which tort law historically had been constructed -- deterrence and compensation -- in favor of seemingly more enlightened theories based largely on concepts of societal insurance and risk spreading. 23/ While many of these

21/ The Rand Corporation, through its Institute for Civil Justice, has produced the best empirical data and analyses available in the area. While the Institute has only been able to research discrete areas of civil justice, the conclusions drawn from those analyses are invaluable to understanding many broader problems. The recently published five-year overview of the Institute's program offers an excellent summary of the research, results and continuing work of the Institute's staff.

22/ For example, at the end of fiscal year 1975, what is now the Torts Branch of the United States Department of Justice contained 39 attorneys, who handled or supervised about 4,000 cases totalling approximately \$1 billion in claims. At the end of fiscal year 1985, the Torts Branch had grown to 124 attorneys handling or supervising about 11,000 cases totalling approximately \$200 billion in claims.

23/ One of the most explicit statements of such a theory can be found in the decision of the New Jersey Supreme Court in Beshada v. Johns-Manville Products Corp., 90 N.J. 191, 447 A.2d 539 (1982), in which the Court expressly denied defendants

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theories were couched in terms of economic efficiency, they represented the beginning of a devastating, and to this day, ongoing challenge to the role of fault as a predicate of tort liability. The long-term effect of this development has been less to promote a more efficient or sensible tort system, 24/ than to undermine the importance of fault (or wrongdoing) as a moral and doctrinal justification for and limitation on tort liability. As this limitation has been removed or undermined in certain areas of tort liability, tort law increasingly has come to rest only on the pillar of compensation, with compensation often awarded merely for the sake of compensation.

As the tort system moves away from fault it increasingly imposes liability upon persons and companies that have done nothing wrong. This has been accomplished in a variety of ways: by directly reducing or even eliminating the fault requirement; by

23/ (FOOTNOTE CONTINUED)

the opportunity to raise a "state of the art" defense. The Court held that even if the danger at issue was scientifically unknowable at the relevant time, defendants nonetheless were still liable for having failed to warn of an unknowable risk. As justification for its holding, the Court relied heavily on risk spreading. In the words of the Court, "manufacturers and distributors . . . can insure against liability and incorporate the cost of the insurance in the price of the product." 447 A.2d at 547. The Court went on to opine that the likely increase in premiums to compensate for unanticipated risks was "not a bad result." Id.

24/ The belief that tort liability should be no-fault so as to serve as a risk spreading mechanism for all injuries is in fact quite anti-consumer. Such a view of tort liability effectively would mean that the price of every product and service would include an insurance surcharge for the risk of any injury related to the product or service. It has long been understood, however, that because of the extraordinarily high transaction costs of the tort system, such compulsory insurance through the tort system would be among the most inefficient and costly ways for consumers to purchase insurance. Thus, for every \$1 of compensation, the tort system requires the consumer to pay approximately \$3 in premiums (assuming, as discussed infra, two-thirds transaction costs), while that same \$1 of compensation can be obtained through first-party health and disability insurance for only \$1.25. H. Manne, Medical Malpractice Policy Guidebook 143 (1985). It is highly ironic that many proponents of no-fault liability argue that such liability is in the best interest of consumers. In fact, since consumers ultimately pay the premiums of whatever compensation scheme is devised, quite the contrary is the case. See also Epstein, "Products Liability as an Insurance Market," 14 J. Legal Stud. 645 (1985).

defining new duties that effectively create fault where no fault existed previously; and, by engaging in after-the-fact analyses that "find" fault wherever there has been an injury. 25/ The ultimate effect of these developments has been the same -- to shift liability for compensation to "deep pocket" defendants that have the resources to compensate plaintiffs generously. 26/

Fault has not, however, been openly (or completely) rejected as part of our tort law. One reason is that fault remains the only vehicle in tort law capable of distinguishing wrongful (or undesirable) from beneficial (or desirable) conduct. If fault were rejected altogether, it would mean that desirable activities would be just as likely to incur liability as wrongful conduct. An open rejection of fault thus necessarily would result in a sweeping transformation in the public's attitude toward tort law, which continues to be bottomed on the concept of tort liability as a form of justified redress for wrongful conduct. A second reason why fault continues to be part of tort law (and why courts often will engage in amazing distortions of relevant facts or legal doctrines to find fault rather than simply reject the principle of fault) is that fault is the basis of much of the structure and process of tort law.

25/ The duty to warn has been a particularly fertile ground for such after-the-fact compensation oriented findings of fault. It is all too easy after the occurrence of an injury to postulate a warning that might have influenced the plaintiff to be more careful or to reconsider his action, no matter how fanciful or unreasonable such a warning might appear prior to the injury. Such analyses have been a major factor in the medical malpractice and product liability litigation explosion.

26/ A recent and almost classic example of such compensation oriented liability findings is the California Supreme Court's decision in Bigbee v. Pacific Tel. & Tel. Co., 34 Cal.3d 49, 665 P.2d 947 (1983). In that case, a man was injured when an allegedly intoxicated driver lost control of her car, veered off the street into a parking lot, and crashed into a telephone booth in which the man was standing. Suit was brought against the companies responsible for the design, location, installation, and maintenance of the booth. The Court, in an opinion authored by Chief Justice Rose Bird, found that the risk that someone might veer off the road and crash into the phone booth was not unforeseeable as a matter of law. The Court also determined that it was of no consequence that the harm to plaintiff came about through the negligent or reckless acts of an allegedly intoxicated driver. In a concluding footnote, Chief Justice Bird stated that "there are no policy considerations which weigh against imposition of liability" against the defendants even though their "conduct may have been without 'moral blame,'" and referred specifically to "the probable availability of insurance for these types of accidents" 665 P.2d at 953 n. 14.

If fault were no longer a central element in determining liability, the current tort system would in many ways be wasteful, inefficient and unfair in the extreme. 27/

Tort law thus has gradually (with a marked acceleration in recent years) been moving in the direction of no-fault liability without an adequate acknowledgement of either the existence or the implications of this development. The result is an increasingly common and perverse combination of fault-based levels of compensation based on no-fault liability.

The Undermining of Causation

Tort law traditionally has sought to place liability only upon those actors whose wrongful conduct actually caused an injury. This principle is found in the concept of "proximate cause," which requires a reasonable relationship between a given cause and effect. For some time, however, proximate cause has been under systematic attack. No single doctrinal change can be identified as the primary vehicle for this attack. Rather, the challenge has come through a variety of questionable practices and doctrinal innovations.

One such development has been the increasing use of joint and several liability to shift the cost of compensation to "deep pockets." Joint and several liability developed in the context of defendants acting in concert. 28/ Over the years, however, it increasingly has been used to make a defendant with only a limited role in causing an injury bear the full cost of compensating plaintiff, even in some cases where the plaintiff may have been largely responsible for his own injury. 29/ The result has been that joint and several liability in the absence of concerted action can and does lead to highly inequitable

27/ For example, the way in which damages are measured and awarded can only be justified, if at all, on the basis of redressing wrongful conduct. Once wrongdoing is removed as an element of liability, many of the principles involving damages become grossly unfair.

28/ See generally Prosser and Keeton on Torts (5th ed. 1984), Chapter 8. As may be obvious, as with so many other aspects of tort law, fault remains a central and essential justification for joint and several liability.

29/ The application of joint and several liability in cases where there in fact is no concerted action is discussed in some detail in Speiser, Krause & Gans, The American Law of Torts § 3:7 (1983). It is interesting to note that the English courts apparently have maintained the traditional common law basis for joint and several liability, and have refused to apply such liability in the absence of concerted action. Id.

treatment of defendants, particularly "deep pocket" defendants. 30/

A related development is the way in which joint and several liability has been applied by some courts to theories of "enterprise" or "market share" liability for injuries caused by generic products (e.g., DES). "Market share" liability, in its pure theoretical sense, allocates liability among manufacturers of a generic product on the basis of their share of the relevant market. While there can be some serious problems and inequities with this approach, as long as all relevant manufacturers (and their respective market shares) are accounted for, and the product is truly generic in nature, such an allocation of liability may be the only way plaintiffs in some cases can obtain compensation for injuries caused by wrongdoing on the part of the manufacturers of such a product. Serious problems with this approach arise, however, when not all relevant manufacturers are accounted for, or where the product is not truly generic in nature. Even more troublesome is the approach of several courts which use some industry liability allocation formula, but then apply joint and several liability to all defendants. See, e.g., Abel v. Eli Lilly & Co., 418 Mich. 311, 343 N.W.2d 164, cert. denied., 105 S.Ct. 123 (1984); Collins v. Eli Lilly Co., 116 Wis.2d 166, 342 N.W.2d 37 (1984). This, in fact, represents a clear abuse of joint and several liability, and cannot be justified on the basis of the unique difficulties plaintiffs sometimes face in identifying the manufacturer of an injury causing generic product.

A third means that has been used to undermine causation -- increasingly common in toxic torts cases -- is the use of presumptions or burden-shifting techniques to force the defendant to prove the lack of causation in order to avoid liability. 31/ Frequently, this amounts to asking the defendant

30/ The legal doctrine of contribution in theory could serve to mitigate some of those inequities. In certain areas of the law, such as antitrust law, where joint and several liability generally tends to be applied to established businesses, contribution appears to function quite well. (And, in any event, joint and several liability in antitrust cases is virtually always based on concerted action -- the traditional basis for such liability.) In personal injury cases, however, many multi-defendant cases involve a "deep pocket" and one or more defendants who are either judgment proof or have limited assets or insurance coverage. In such cases, the belief that contribution serves as a mitigating factor is largely illusory.

31/ A particularly dramatic example of such a practice can be found in Allen v. United States, 588 F.Supp. 247 (D. Utah 1984), a low-level radiation exposure case in which the court shifted to the government the burden of proving that particular cancers were not caused by radiation exposure.

to meet an impossible burden of proving the negative.

Another way in which causation often is undermined -- also an increasingly serious problem in toxic tort cases -- is the reliance by judges and juries on noncredible scientific or medical testimony, studies or opinions. It has become all too common for "experts" or "studies" on the fringes of or even well beyond the outer parameters of mainstream scientific or medical views to be presented to juries as valid evidence from which conclusions may be drawn. The use of such invalid scientific evidence (commonly referred to as "junk science") has resulted in findings of causation which simply cannot be justified or understood from the standpoint of the current state of credible scientific and medical knowledge. ^{32/} Most importantly, this development has led to a deep and growing cynicism about the ability of tort law to deal with difficult scientific and medical concepts in a principled and rational way.

These are but four developing areas that are causing defendants to be found liable for injuries they did not cause. The one common attribute of these developments is that the defendants to whom liability is shifted almost invariably happen to be those with the deepest pockets.

The Explosive Growth in Damage Awards

Another area of great concern is the explosive growth in tort damages awards over the last decade. A few statistics will illustrate this point.

Jury Verdict Research, Inc., publishes data on the average jury verdict in product liability and medical malpractice cases. The service's latest report ^{33/} shows that the average medical

^{32/} An instructive decision in this regard is the district court opinion in Johnston v. United States, 597 F.Supp. 374 (D. Kansas 1984). The court there exhaustively reviewed the theories and credentials of a number of plaintiffs' experts on the effects of low-level radiation, and rejected their testimony as biased, contradictory and totally without scientific merit. Of particular interest is the court's frustration that these same experts had played prominent roles in major radiation cases such as Silkwood and Allen, and that their testimony was being used in numerous cases throughout the country. The court noted its disappointment that such "so-called experts can take such license from the witness stand [to] say and conclude things which . . . they would not dare report in a peer-reviewed format." Id. at 415.

^{33/} Jury Verdict Research, Inc., Injury Valuation: Current Award Trends No. 304 (1986). The 1985 data provided by the service is incomplete, and is subject to refinement. The

(CONTINUED)

malpractice jury verdict increased from \$220,018 in 1975 to \$1,017,716 in 1985 (see Chart D), a 363% increase. 34/ Average product liability jury verdicts during this same period increased from \$393,580 to \$1,850,452, a 370% increase (see Chart E). 35/

Interestingly, much of this increase can be attributed to a remarkable growth in verdicts above \$1 million. In 1975 there were three million-dollar medical malpractice verdicts and nine million-dollar product liability verdicts reported by Jury Verdict Research, Inc. In 1984, the numbers had grown to 71

33/ (FOOTNOTE CONTINUED)

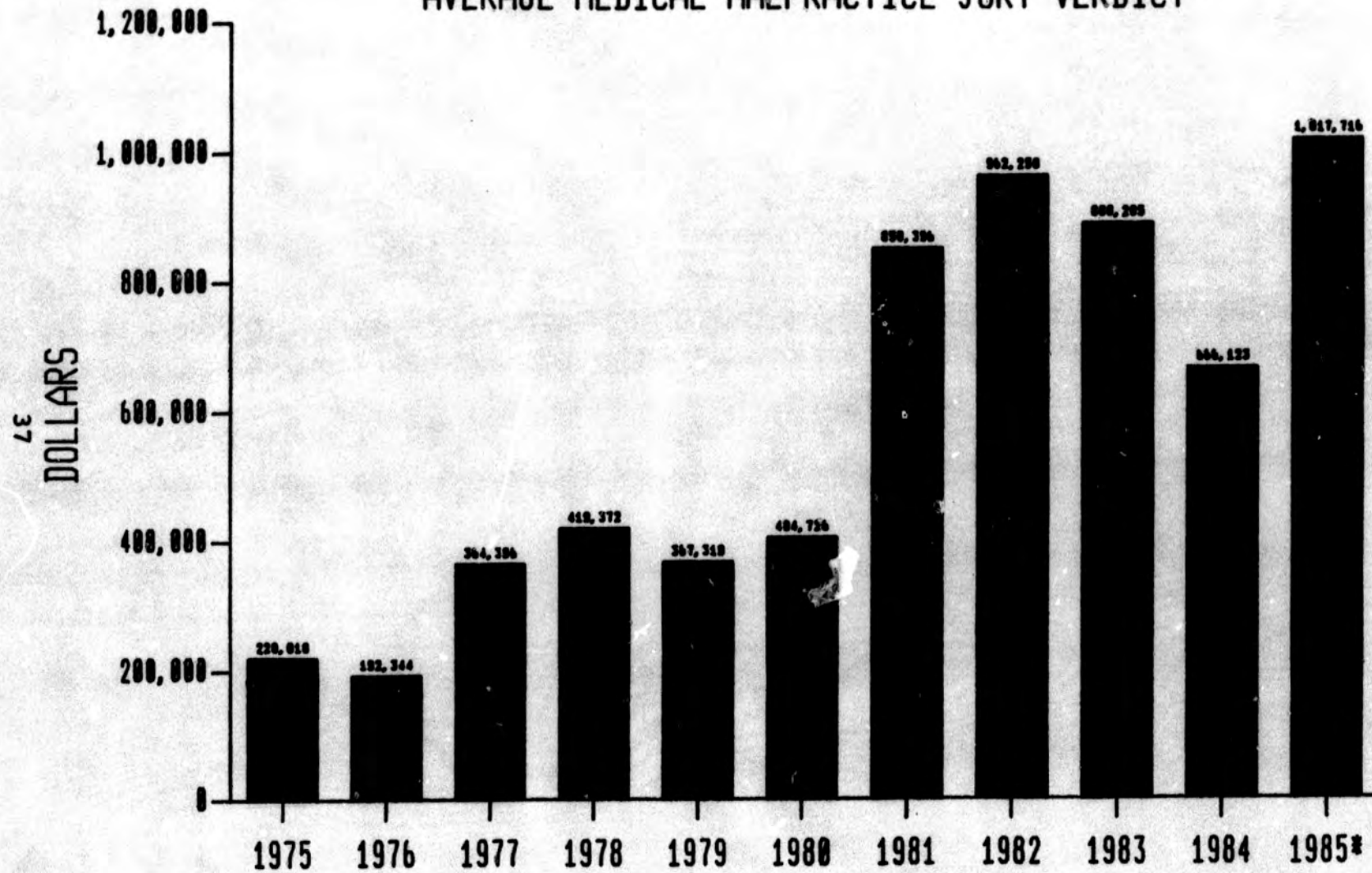
service indicates that it bases "its findings, values and probabilities upon collected verdicts using accepted statistical methods in their analysis and application." Nevertheless, the reported average annual verdicts are not used by the Working Group as an accurate statement (though they may very well be) of the average jury verdict in any particular year. Rather, the Working Group found the Jury Verdict Research data useful for purposes of showing the trend in jury verdicts over the last decade. In this regard, it should be noted that the service has used the same basic methodology since well before the relevant reported years. Moreover, while there are different estimates of average jury verdicts for particular areas and years, a number of other sources that have collected such data -- including the Institute for Civil Justice -- corroborate the overall trends reported by Jury Verdict Research, Inc.

34/ This percentage increase is consistent with a survey of California Superior Court medical malpractice verdicts. That survey shows the average medical malpractice award as increasing from \$152,970 in 1975 to \$649,210 in 1983, a 324% increase. American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the '80s (October 1984). Because the \$250,000 cap in California on awards for non-economic damages in medical malpractice cases was only recently affirmed as constitutional (see Chapter 4), it is unclear what effect, if any, the cap has had on malpractice verdicts in California. It is worth noting, however, that the recent insurance problems for medical malpractice have been far less serious in California than in many other states, and that in California the insurance crisis primarily has affected areas other than medical malpractice (e.g., municipal liability).

35/ This remarkable increase is also reflected in the Institute for Civil Justice study of civil jury verdicts in Cook County, Illinois. For example, the average wrongful death award in Cook County increased (in constant dollar terms) from \$166,000 in 1970-74 to \$336,000 in 1975-79, a doubling over roughly half a decade. M. Peterson, Compensation of Injuries: Civil Jury Verdicts in Cook County 54 (1984).

CHART D

AVERAGE MEDICAL MALPRACTICE JURY VERDICT

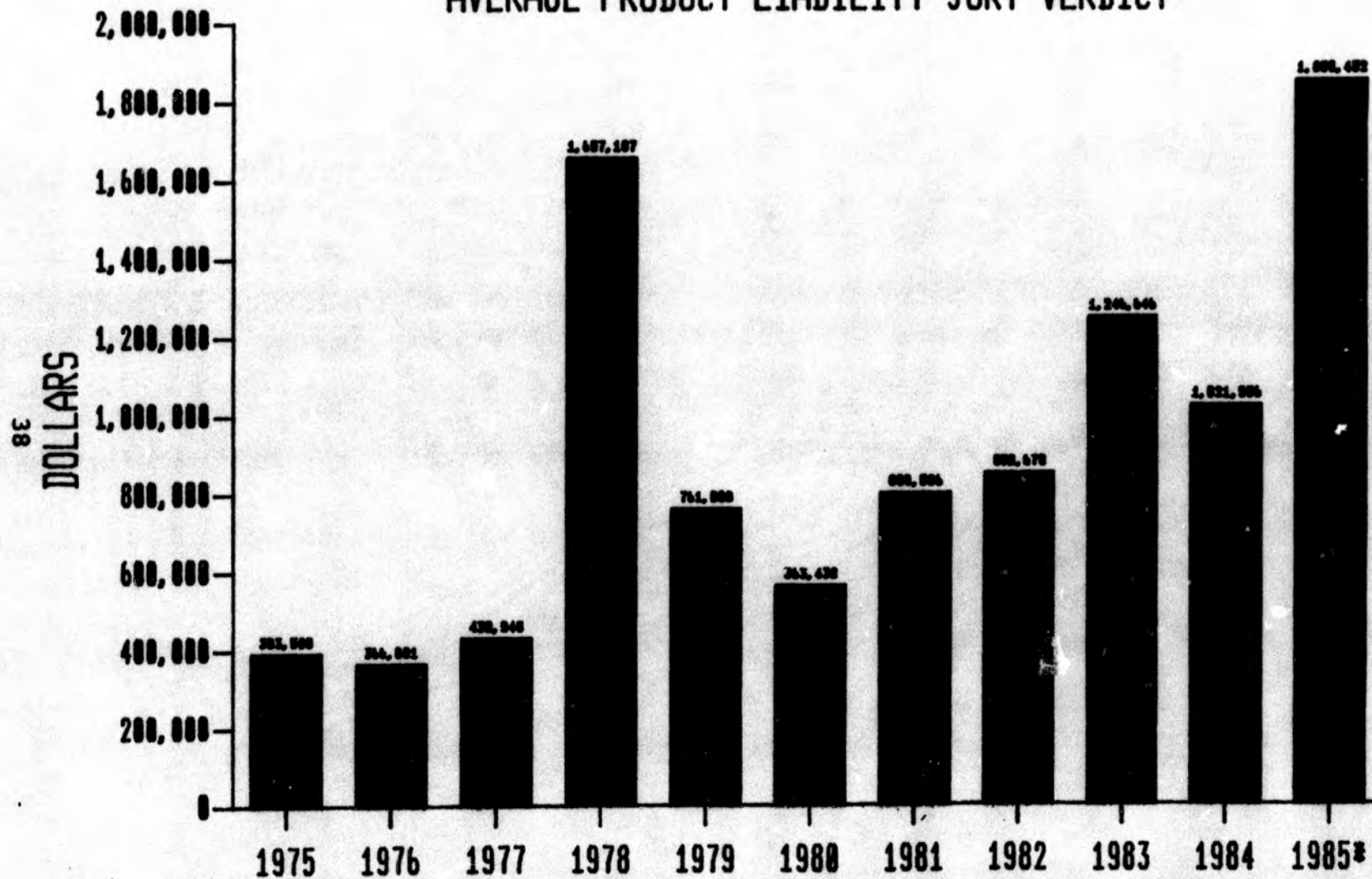


Sources: Jury Verdict Research, Inc.

* 1985 Information Not Complete

CHART E

AVERAGE PRODUCT LIABILITY JURY VERDICT



Sources: Jury Verdict Research, Inc.

* 1985 Information Not Complete

million-dollar medical malpractice verdicts and 86 million-dollar product liability verdicts (see Chart F), an increase of over 1200% in the number of such verdicts. 36/ If these million-dollar verdicts are deleted, the increase in average verdicts is reduced sharply. For example, the increase in the average medical malpractice jury verdict from 1975 to 1985 drops to 26% and the comparable average product liability verdict jury increase is 87%. 37/ This clearly suggests that the explosion in damages has come largely at the high end of the awards scale.

The Jury Verdict Research data is of only limited value on the absolute number of million-dollar payments, since in all likelihood the vast majority of such payments are through settlements rather than verdicts. The data is highly relevant, however, in that it shows that the percentage rate of increase of verdicts is far higher for large verdicts than for small or medium-size verdicts. Since a significant distinguishing factor between large verdicts and small or medium-size verdicts is that large verdicts tend to be composed to a far greater extent of non-economic damages, 38/ this strongly suggests that non-economic damages play a major role in the explosive growth in large verdicts (as compared to the much more moderate growth in small and medium-size verdicts).

While it is not possible to quantify precisely how much particular elements of damages have contributed to this explosion, it appears that non-economic damages are a substantial factor. Such damages include non-pecuniary compensatory damages for intangible injuries such as pain and suffering and mental anguish, as well as punitive damages. Such non-economic damages are inherently open-ended and subjective, and, therefore, easily susceptible to dramatic inflation. Of interest in this regard is a recent preliminary study by the Institute for Civil Justice which indicates that the average punitive damage award in Cook County, Illinois, increased from \$63,000 in 1970-74 to \$489,000 in 1980-84 (see Chart G). 39/ Of

36/ Jury Verdict Research, Inc., supra. The trend toward million-dollar verdicts is also documented by the Institute for Civil Justice. M. Shanley & M. Peterson, Comparative Justice: Civil Jury Verdicts in San Francisco and Cook Counties, 1959-1980 26-30 (1983).

37/ Jury Verdict Research, Inc., supra.

38/ H. Manne, Medical Malpractice Policy Guidebook 138-39 (1985). The study shows that for medical malpractice awards between \$100,000 and \$200,000, non-economic damages account for approximately 27% of the total award, while for awards above \$600,000, the non-economic share increases to 54%.

39/ M. Peterson, Punitive Damages: Preliminary Empirical

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CHART F

MILLION DOLLAR JURY VERDICTS

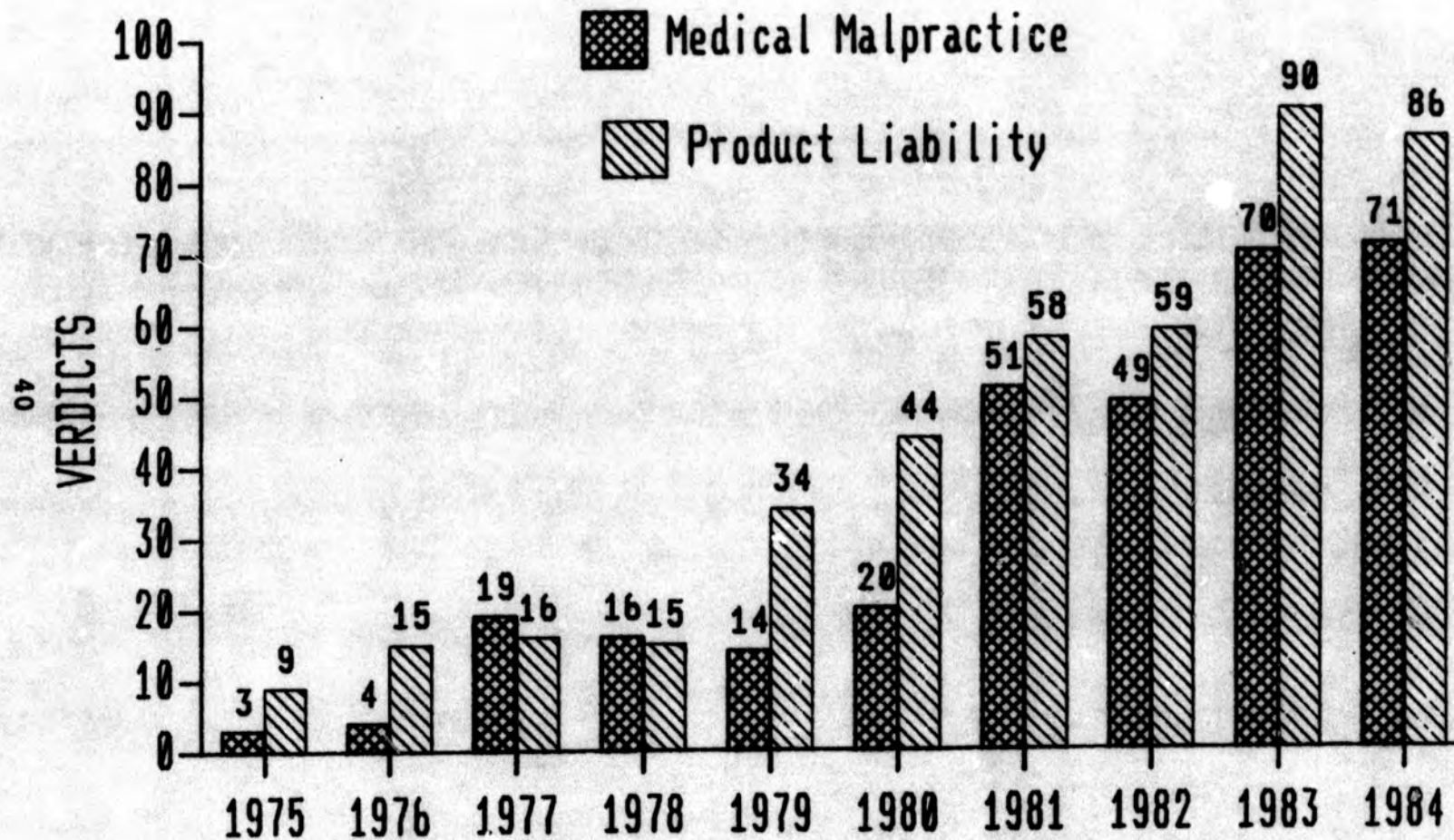


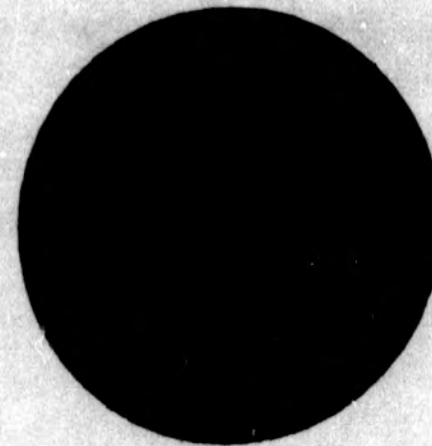
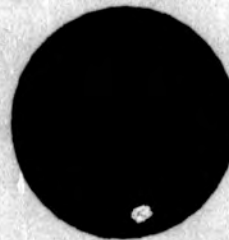
CHART G

AVERAGE PUNITIVE DAMAGE AWARD IN COOK COUNTY*

\$63,000
(25 Awards)

\$135,000
(39 Awards)

\$489,000
(90 Awards)



1970-74

1975-79

1980-84

Source: Institute for Civil Justice

*1984 Dollars

particular interest is that the average Cook County punitive damage award in personal injury cases increased from \$40,000 in 1970-74 to \$1,152,174 in 1980-84 (see Chart H). 40/

This explosion in damage awards, particularly in the case of non-economic damages, is vastly in excess of the rate of inflation over the comparable period. 41/ For whatever reasons, tort damage awards have suddenly soared in the United States without any apparent justification.

Excessive Transaction Costs

Another serious problem of the tort system is its extraordinarily high transaction costs. A study by the Institute for Civil Justice of the asbestos litigations shows that out of every dollar paid out by the asbestos manufacturers and their insurers as a result of the asbestos litigation, 62 cents on the average is lost attorneys' fees and litigation expenses (see Chart I). 42/ This does not include the transaction costs borne by the courts in adjudicating these claims.

It also is worthwhile viewing the transaction costs from the

39/ (FOOTNOTE CONTINUED)

Findings 13 (1985). These averages were adjusted for inflation and are stated in terms of the 1984 dollar. The study's analysis of punitive damage awards in San Francisco also showed an increase in such awards, though of lesser magnitude than in Cook County.

40/ Id., at 25 (also adjusted for inflation). Peterson notes that personal injury punitive damage awards in Cook County between 1980-84 amounted to over half of all punitive damages awarded in all case categories by Cook County juries from 1960-84.

41/ For purposes of comparison, one dollar in 1985 had approximately half the buying power of one dollar in 1975.

42/ J. Kakalik, P. Ebener, W. Felstiner, G. Haggstrom & M. Shanley, Variations in Asbestos Litigation Compensation and Expenses xviii (1984). These costs, of course, include both plaintiffs' and defendants' litigation expenses. In comparing the costs attributable to defendants' litigation expenses to the costs attributable to plaintiffs' litigation expenses it is useful to remember that defendants incur such costs whether or not they prevail, and, indeed, may incur substantial costs defeating even clearly frivolous claims. Measurements of plaintiffs' litigation expenses (such as in Chart I), reflect only those cases in which plaintiffs prevail, while defendants' litigation expenses include all cases, whether or not plaintiffs prevail.

CHART H

AVERAGE PERSONAL INJURY PUNITIVE DAMAGE AWARD IN COOK COUNTY*

\$40,000
(5 Awards)

\$217,000
(6 Awards)

\$1,152,000
(23 Awards)

1970-74

1975-79

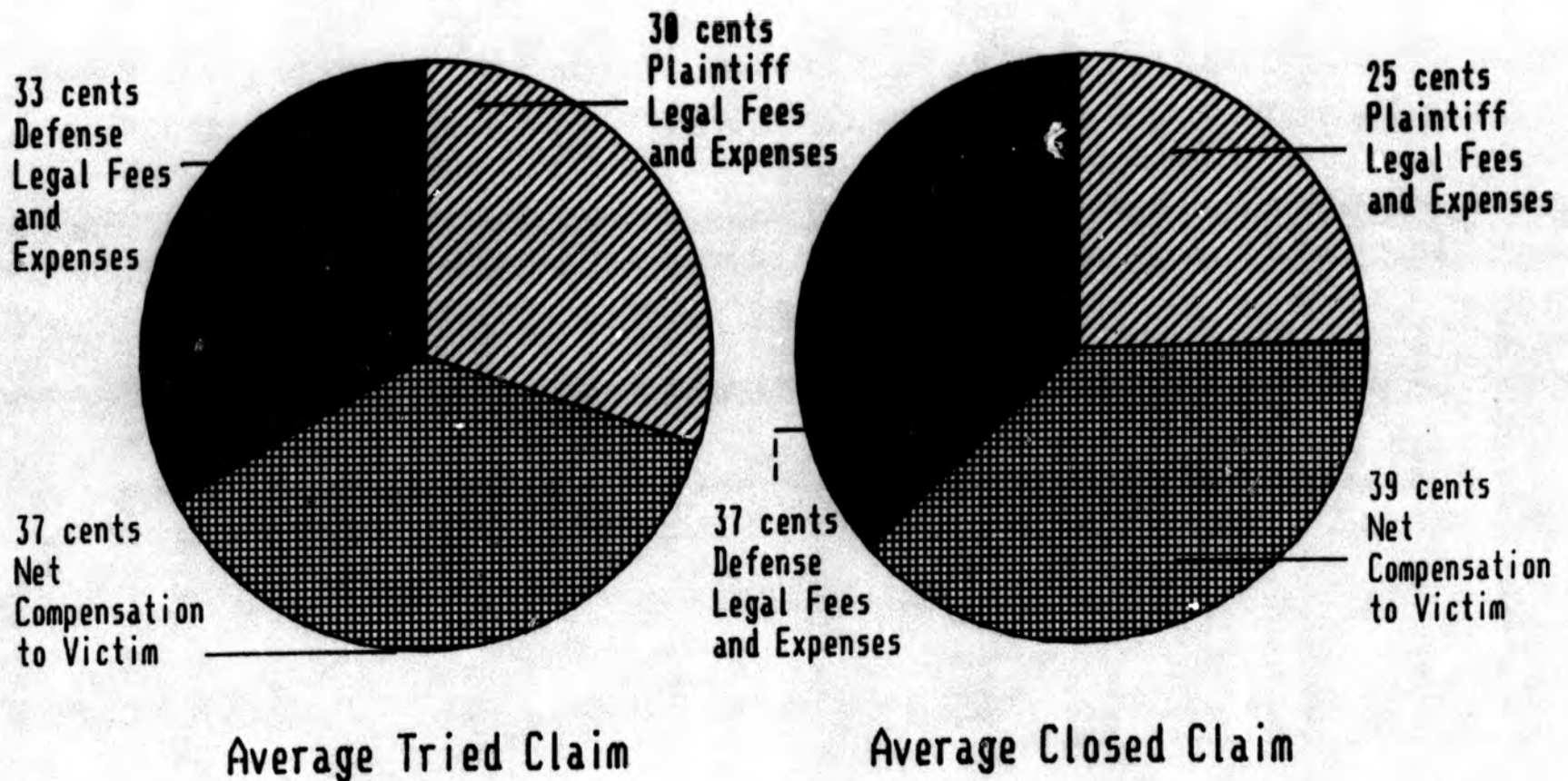
1980-84

Source: Institute for Civil Justice

*1984 Dollars

CHART I

ALLOCATION OF EVERY DOLLAR PAID OUT IN ASBESTOS CLAIMS



Source: Institute for Civil Justice

perspective of the prevailing plaintiff. The study also shows that for every dollar awarded to plaintiff, 34 cents on the average is lost to legal fees and an additional 5 cents is lost to legal expenses. ^{43/} In some cases, legal fees alone amounted to as much as 45% of plaintiff's award. ^{44/}

It is difficult to justify such extraordinary transaction costs. But it is particularly difficult to justify such costs when the costs often are borne largely by the seriously injured and by consumers who ultimately must pay for these costs through higher prices for goods and services. The only clear beneficiaries of this system appear to be lawyers.

II. BURGEONING TORT LIABILITY AS A MAJOR CAUSE OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above discussion describes a tort system that in recent years has dramatically increased in scope. One way of measuring that increase is in terms of the increase in the number of tort lawsuits and in the level of damages awarded in such lawsuits. While the available data is limited, and by no means perfect, it clearly confirms that there has been a substantial increase in recent years in both the number of tort lawsuits and awarded damages.

The growth in the number of product liability suits has been astounding. For example, the number of product liability cases filed in federal district courts has increased from 1,579 in 1974 to 13,554 in 1985, a 758% increase (see Chart J). ^{45/} There is no reason to believe that the states courts have not witnessed a similar dramatic increase in the number of product liability claims.

A similar trend can be found in medical malpractice, where claims ^{46/} filed against physician-owned companies increased from 10,568 in 1979 to 23,545 in 1983, a 123% increase in four

^{43/} *Id.*, at 84. For tried claims, these costs increase to 39 cents and 6 cents respectively. *Id.*

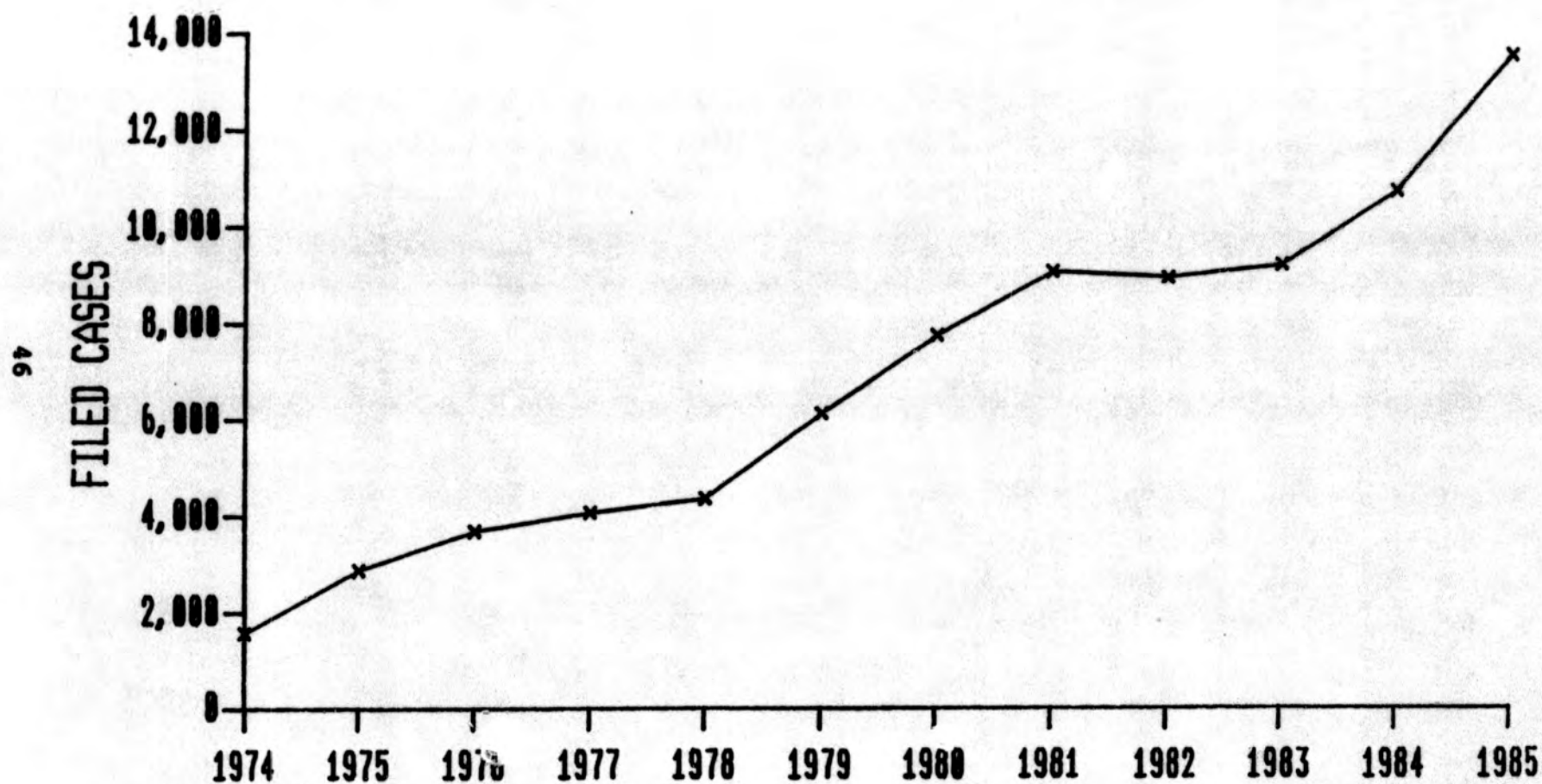
^{44/} *Id.* With legal expenses of 5%, prevailing plaintiffs in such cases receive only half of the awarded verdict.

^{45/} Administrative Office of the United States Courts.

^{46/} Claims do not, of course, translate directly into lawsuits, since most claims are resolved prior to the filing of litigation. But a substantial increase in claims almost certainly means a corresponding substantial increase in litigation.

CHART J

PRODUCT LIABILITY CASES FILED IN FEDERAL DISTRICT COURT



Source: Administrative Office of the United States Courts

years. 47/ The number of medical malpractice lawsuits per 100 physicians more than doubled from 1976 to 1981, and for obstetricians/gynecologists actually tripled during this period. 48/ In federal courts, which contain only a fraction of all medical malpractice claims, such claims have increased almost three-fold in the last decade (see Chart K). 49/

A similar increase can be found in claims filed against municipal and county officials. A survey of over twelve hundred local governments found that such claims had increased by 141% between 1979 and 1983. 50/ Tort claims against municipalities also have increased dramatically in recent years. For example, New York City witnessed a 375% increase from 1977 to 1985 in personal injury claims, with a corresponding 345% increase in average settlement cost. 51/ The City's long-term liability for tort claims already filed is projected to be \$1.5 billion. 52/

The explosive growth in damages over the past decade has already been related in detail. Suffice it to say that the increase in the average tort award appears to have outpaced even the extraordinary increase in the number of such lawsuits. The extent of some of these increases are difficult to comprehend. For example, one verdict reporting service found that the average jury verdict in personal injury lawsuits had increased by approximately 25% or more in three separate years (24.5% in 1980, 30.49% in 1981 and 27.54% in 1983). 53/ The average annual increase in such awards since 1975 has been over 15%. 54/ A subcategory of damages that dramatically illustrates this development is the average jury verdict for the wrongful death

47/ American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the '80s 6 (November 1984).

48/ H. Manne, Medical Malpractice Policy Guidebook 18 (1985).

49/ Administrative Office of the United States Courts.

50/ Wyatt Co., Public Officials Liability Insurance: Understanding the Market (1986), page 22 (the provided 1984 data is incomplete, see pages 9-10, and therefore is not used for comparison).

51/ Statement by Mayor Edward I. Koch before the Governor's Advisory Commission on Liability Insurance, February 21, 1986.

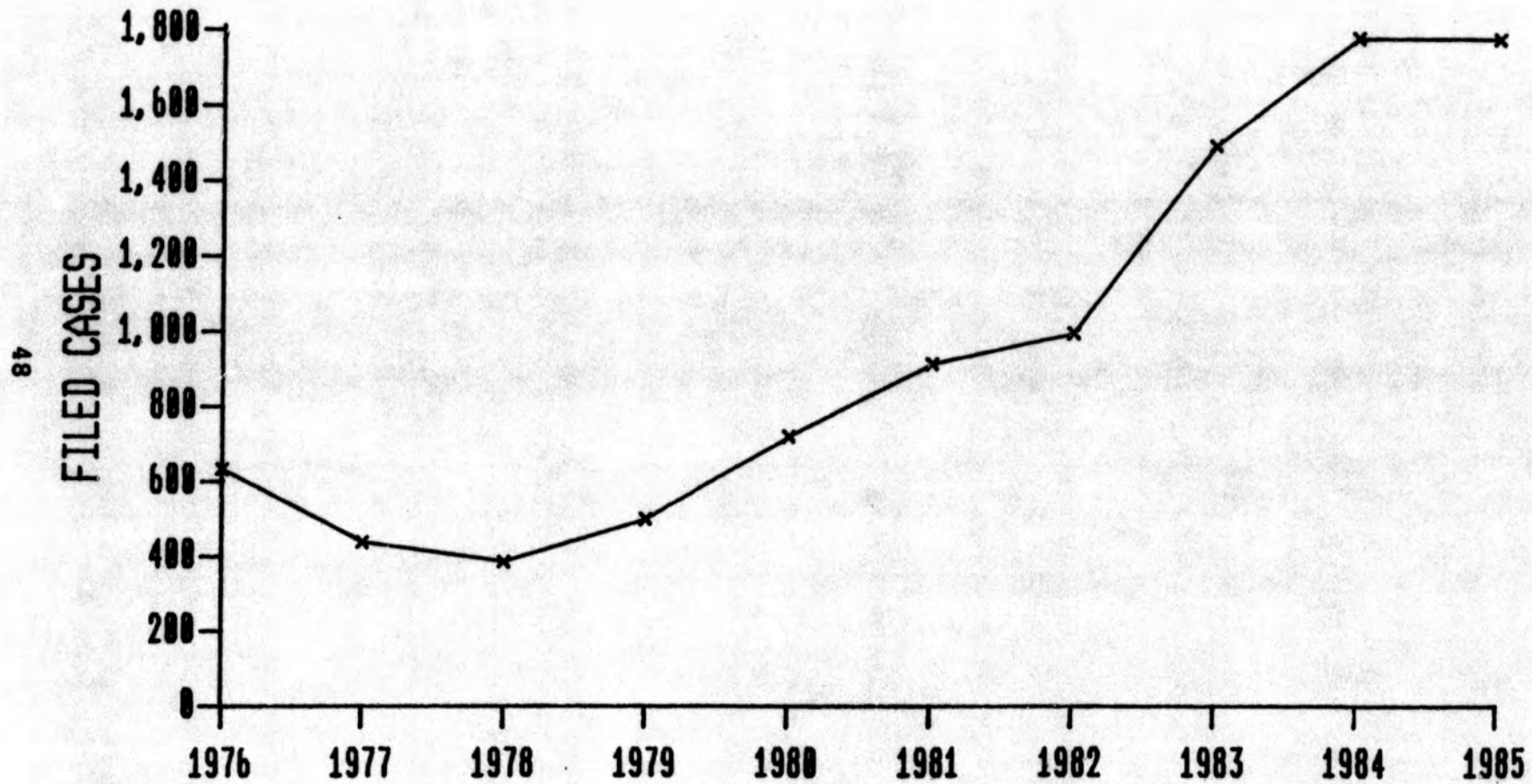
52/ Id.

53/ Jury Verdict Research, Inc., supra.

54/ Id. This is more than double the average annual CPI increase during the same period. Id.

CHART K

MEDICAL MALPRACTICE CASES FILED IN FEDERAL DISTRICT COURT



Source: Administrative Office of the United States Courts

of an adult male. The average award increased from \$223,259 in 1975 to \$946,140 in 1985, a more than four-fold (324%) increase in ten years (see Chart L). 55/

The increase in the number of tort lawsuits and the level of awarded damages 56/ (or settlements) in and of itself has an obvious inflating effect on insurance premiums. To illustrate, assuming all other factors are held constant, 57/ if the number of lawsuits against a company or person doubles in ten years, and if the average damage award (or settlement) doubles over this same period, that company or person will experience at least a four-fold increase in insurance premiums over those ten years. As noted above, however, for both medical malpractice and product liability the last ten years have witnessed much more than a doubling in lawsuits and average awards.

The above observation leads to an important but troubling insight into the current insurance availability/affordability crisis. Some have speculated that the crisis is the result of the attempt by the insurance industry to recoup losses resulting from its underpricing in the late 1970's and early 1980's. If this theory is correct, then it would seem likely that as such losses are recouped, premiums would decline. The above analysis, however, suggests that while the insurance industry may have underpriced its product for a period of time, the current explosion in premiums results in large part from the fact that now that the insurance industry is facing substantial underwriting losses, it must price coverage to reflect the actual risks presented by tort law. In other words, for a variety of reasons, the insurance industry appears to have kept prices constant or engaged in price reductions in a period during which the risks generated by tort liability increased

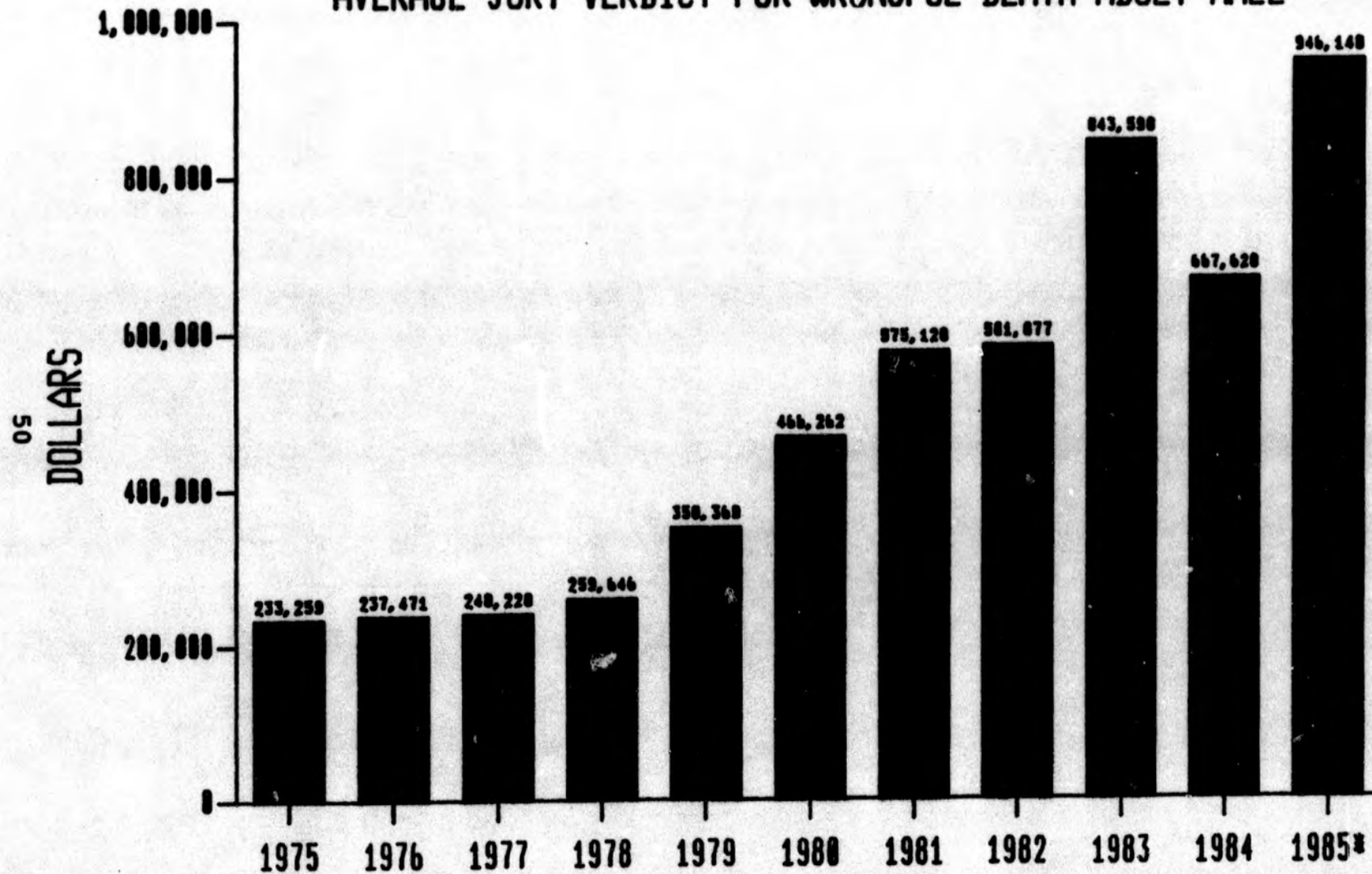
55/ Id.

56/ Jury verdicts, of course, represent only the tip of the claims resolution process. Most claims are resolved before trial. However, settlements by their very nature reflect the range of verdicts available to the plaintiff. Thus, as jury verdicts skyrocket, so do settlements. Settlements also reflect the plaintiff's likelihood of success. As tort law becomes more and more favorable to plaintiffs -- particularly in reducing or even eliminating plaintiff's burden of showing fault or causation -- settlements further increase. Accordingly, in addition to the obvious effect on settlements of increasing jury verdicts, liberalized standards of fault and causation increase the percentage of claims resolved favorably to plaintiff and increase the size of settlements.

57/ Of course, all factors are not held constant. For example, if there is an increase in the percentage of claims resolved favorably to plaintiffs, premiums would have to be increased correspondingly.

CHART L

AVERAGE JURY VERDICT FOR WRONGFUL DEATH ADULT MALE



Source: Jury Verdict Research, Inc.

* 1985 Information Not Complete

dramatically. Now that the industry is attempting to match premiums to risk, there appears to be a dramatic, pent-up increase in premiums to bring premiums back into line with rapidly growing liability risks.

The above analysis, if correct, is troubling in that it suggests that even after the insurance industry's underwriting profitability is restored, premiums are likely to remain relatively high. That is, while the more extreme availability problems may be resolved once the industry controls its underwriting losses, affordability problems may remain as a long-term fixture absent significant reforms of tort law.

There is, however, another important contribution of recent developments in tort law to the availability/affordability crisis which goes beyond the number of lawsuits and size of damage awards. The changing standards of liability and causation have generated tremendous uncertainty. The "rules of the game" of tort liability have changed so dramatically and rapidly in recent years that few are willing to speculate on what those rules will be even a few years hence. Invariably, however, those rules seem to have been changed to the prejudice of parties with pockets sufficiently deep to bear increasingly generous awards of compensation.

This uncertainty as to what the rules of tort liability applicable to any particular company, person or activity will be in future years makes it extremely difficult for the insurance industry to assess risk (and establish appropriate premiums) with any degree of confidence. This undoubtedly exacerbates the affordability problem, and may be a major factor underlying the availability problem. Simply put, insurance, like other business activities, operates most efficiently within a stable legal regime. Tort law, unfortunately, over recent years has been anything but stable.

The recent explosion in tort liability and the lack of legal certainty is a particularly noxious combination that seems to react almost synergistically in promoting the insurance availability/affordability crisis. The rapidly accelerating growth in both the number of tort lawsuits and the size of damage awards in and of itself significantly increases future liability risks. But that risk is magnified by the perception -- based in large part on the lack of a stable legal regime -- that this accelerating growth will continue unabated. The insurance industry thus appears to be extrapolating the massive liability surge of recent years into the future, and seems to be setting its rates in part on the assumption that the on-going deterioration of tort law will continue for some time. Simply put, assessments of future liability risks reflect not only the recent rapid growth in such risks, but the perceived likelihood

that past excesses will be outpaced by the excesses yet to come. 58/

In conclusion, the current problems of tort law can be summarized as follows:

- ° Too many defendants are found liable (or forced into settlements) where there should be no liability, either because they engaged in no wrongful activity, or because they did not cause the underlying injury.
- ° Damages have become excessive, particularly in the area of non-economic damages such as pain and suffering, mental anguish and punitive damages. And,
- ° Transaction costs are far too high.

The ways in which these aspects of the tort system are contributing to the current insurance availability/affordability crisis can be summarized as follows:

- ° The private sector is being asked to carry a compensation burden which in some instances it simply cannot afford to carry without substantial economic dislocations. Thus, even where insurance is available, in order to carry this compensation burden, it often is priced at unacceptable levels.
- ° The affordability/availability problem is greatly exacerbated by the lack of a stable legal regime which would allow the insurance industry to assess liability risks with some degree of confidence.

58/ A recent Administration study of the childhood vaccine industry, for example, found that uncertainty as to tort liability was a major factor underlying the severe insurance availability problems facing the industry and jeopardizing the childhood vaccination program. See the Report of the Working Group on Vaccine Supply and Liability (April, 1985).

CHAPTER 3

RECENT INSURANCE INDUSTRY DEVELOPMENTS

The insurance availability/affordability crisis has led both the insurance industry and its customers to consider various changes to the ways in which liability risks are insured. The following is a description of the most significant of these developments and their immediate implications.

I. COVERAGE CHANGES

One of the most important of these changes has been the development of new commercial policy forms by the Insurance Services Office ("ISO"), the statistical and rate-making organization for the property-casualty industry. While these new forms have been filed with each state insurance department, most states have not yet acted on the new submissions.

These new policy forms are more limited in scope than the old forms in that they are written on a claims-made basis and permit certain coverages to be excluded entirely.

Claims-Made Policies

General liability insurance, including product liability coverage, traditionally has been written on an occurrence basis; that is, the policy applies to all injuries and damages that occur during the policy period irrespective of when claims are presented. Under claims-made coverage, the policy covers injuries and damages which occur during the policy period and for which claims are filed during the policy period.

The ISO submission provides that a policyholder can purchase unlimited tail coverage (the period during which claims are covered after termination of the policy) for a cost of up to 200% of the original premium. In addition, a five year extended claims reporting period for known claims is provided for situations where no other insurance is applicable. There is still disagreement over the reinstatement of aggregate policy limits for tail coverage and the effect of defense cost inclusions.

A claims-made policy covers claims occurring after the "retroactive date," ordinarily, the inception date of the policy. Under some circumstances, insurers will be permitted to advance the retroactive date, necessitating the purchase of tail coverage for incidents occurring during the prior period. The retroactive date may be advanced when: (1) there is a change of insurer, (2) there is a change in the insured's operation, (3) if the insured fails to inform the insurer of risks he knew or should have known about, or (4) with the consent of the insured.

The ISO has indicated that it does not intend to limit the use of claims-made policies to specific problem areas such as long-tail or latent injury exposures.

The claims-made forms have not yet been approved by the states, and twelve states have expressly disapproved them as filed. The ISO is working with the Insurance Commissioners to resolve differences.

The insurance industry has indicated that it wishes to use claims-made policies. In general, 1986 is viewed as a transition year during which insurers will train their personnel in the use of the new policy forms and adapt their computers to accommodate the changes. Insurers have indicated that in states where the new forms are not insured, they may use non-admitted subsidiaries or surplus lines carriers to provide the coverage to their clients on claims-made basis for large complex risks and risks in "volatile" classes, or else simply not provide coverage to those risks.

Claims-made policies and other limited coverages also are being adopted by reinsurers. Lloyd's of London has introduced a new claims-made form, as have Weavers and Trenwick American Reinsurance. Each policy is somewhat different. Trenwick, a United States reinsurance company, has stated that it will not write any general liability reinsurance on an occurrence basis after January 1 of this year. Trenwick also has written a claims-made form for use by its ceding companies for "difficult" risks. Other reinsurers have indicated they would reinsure both occurrence and claims-made policies, but would strongly encourage the use of claims-made for heavy casualty risks. As indicated in Chapter 1, some businesses already have been asked to take claims-made coverage for their excess limits coverage. Because of the many different claims-made forms currently being used, this is likely to cause gaps in coverage.

Laser Endorsements

The ISO policy form also includes "laser endorsements" which can be used to limit coverage. These provisions permit an insurer to exclude claims from a specific incident, product or period of time. Several Insurance Commissioners have objected to this provision and stated that, at a minimum, it should be revised to require the signature of the insured indicating an awareness of the exclusion. The inclusion of a laser endorsement would necessitate either the insured's purchase of tail coverage for that product or incident, or the insured's "going bare" for that liability.

Pollution Exclusion

Both the new ISO and Lloyd's of London claims-made commercial general liability policies specifically exclude pollution

coverage. Traditionally, the general liability policy has included the business community's liability for damage caused by the "sudden and accidental" discharge of toxic substances. Environmental Impairment Liability ("EIL") policies are used to cover damages from gradual pollution incidents. In a number of highly controversial cases, courts have expanded the meaning of "sudden and accidental," causing insurers to be liable for EIL-type (gradual pollution) coverage when it was not intended under the policy.

As a result, insurers currently are reluctant to provide any pollution coverage, though Lloyd's of London has indicated a willingness to cover some liability at additional cost on a "named peril" basis only.

Defense Cost Inclusion

Ordinarily, the costs of defending against liability claims are not included within the aggregate limits of the commercial general liability policy. Insurers traditionally have controlled the defense of claims against their insureds by engaging defense counsel and by governing the vigor with which a claim is challenged. The insurers paid all costs, and the full amount of the policy limits were available to pay any settlement or judgment against the insured.

During the product liability crisis of the mid-1970's there were a number of allegations that insurers were, in fact, fueling the claims situation by settling too quickly in many cases that the insureds believed should have been more vigorously contested. As a result, many companies insisted that their insurance contracts include a right to at least partial, if not full, control of defense strategy.

In the mid-1980's, defense costs have escalated rapidly, mostly because of the cost of attorneys' fees, and possibly, in part because of the insureds' desires to contest claims to the fullest degree possible.

In order to control costs, the ISO had proposed to change the commercial general liability form to include defense costs within the aggregate limits of the policy. This practice already is incorporated in at least some other policy forms. 1/

1/ Business Insurance, December 9, 1985, page 1.

The proposal brought a sharp response from insureds, the bar, and the Risk and Insurance Management Society, a trade association of risk managers and insurance buyers. They believe that there will be cases of defense costs exceeding the limits, leaving no money to pay a settlement or judgment. Some are concerned that defense counsel may urge settlement of unworthy claims in order to prevent defense costs from exhausting all available coverage. Others believe that there will be a spate of bad faith claims against insurers when the policy limit is used for legal costs and the insured is left liable for damages.

In response to the concerns of insurance customers, regulators and brokers, the ISO has revised its proposal so that up to 50% of the aggregate limits may be spent on defense costs before the policy limits will begin to be reduced by those expenses. An endorsement will be available so that up to 300% of the limit may be spent on defense costs before the policy limit is affected. A discount will be applied if the policyholder buys less than the 300% endorsement. Insurers apparently will have the option to apply an endorsement which will charge all defense costs to the policy limits. 2/

At its annual meeting in December, the National Association of Insurance Commissioners passed a resolution urging states not to approve the ISO proposal until the proposal can be studied by the Commissioners. The ISO, which had hoped to initiate the defense cost change in July of 1986, will postpone filing its request with the states until at least February 15, 1986. 3/

II. ALTERNATIVE INSURANCE MECHANISMS

As liability insurance becomes unavailable or unaffordable, means of liability protection outside the conventional insurance markets increasingly are being sought and used.

2/ Business Insurance, December 16, 1985, page 1.

3/ Business Insurance, December 23, 1985, page 1.

Insurance Company Creation (Captive or Other)

One response available to large companies unable to buy the insurance coverage they need is to set up their own insurance company. Thirty-three major United States companies recently have established an offshore insurer, A.C.E. Insurance Company, which began operation in November, 1985, and provides up to \$150 million in liability coverage. Founding companies include IBM, GE, U.S. Steel and Chase Manhattan, as well as other companies. While A.C.E. offers coverages not available elsewhere, its policies are available only to large companies since it only pays claims exceeding \$100 million.

In addition, it recently was announced that a group of fifteen chemical and petrochemical companies are creating a company called CASEX, which would provide excess limits coverage for products, directors and officers, and sudden and accidental pollution liability.

Another group of fifty United States banks are creating a mutual insurer, Bankers' Insurance Co., Ltd., to provide directors and officers liability coverage and bankers blanket bonds.

During the medical malpractice crisis in the early to mid-1970's, groups of medical professionals unable to obtain malpractice coverage formed their own companies, commonly known as bedpan mutuals, to handle their claims. Such insurance groups currently provide about half of the coverage in the malpractice liability market.

Self-Insurance

Some industry groups and trade associations, as well as municipalities in several states, have joined together to self-insure as groups, and others have been able to set up a formal self-insurance program just to handle their own claims. ^{4/}

Self-insurance, either individual or group, also has been a useful vehicle for municipalities for which insurance has become either unavailable or unaffordable.

One major problem encountered by firms seeking to set up self-insurance programs is that reserves for self insurance are not

^{4/} A formal self-insurance program is different from "going bare" in that the former sets up reserves to cover claims and treats it similar to an insurance system whereas the latter simply hopes claims do not occur, which may cause financial difficulties if and when they do occur.

accorded the same tax treatment as insurance company reserves, in that self-insurance reserves are fully taxable. While this presents no problem for municipalities and other tax-exempt entities, it is a major hurdle for private entities.

Small firms are generally unable to establish a meaningful self-insurance program individually, but may benefit from group self-insurance if no other insurance is available.

Product Liability Risk Retention Act Groups

The Risk Retention Act ("RRA"), 15 U.S.C. § 3901 et seq., was intended as a mechanism to (1) create an alternative product liability insurance market, and (2) provide a means for smaller insurance buyers to purchase general liability insurance -- including product liability coverage -- as groups. The RRA evolved from an intensive interagency study of the product liability "crisis" in the mid-1970's. President Reagan signed the Act in September 1981, noting that it was a "marketplace solution" to provide product manufacturers, distributors and sellers with affordable product liability insurance.

A Risk Retention Group ("RRG") is formed by any number of product sellers as an insurance company licensed to operate under the laws of any state. The RRG may provide only product liability and completed operations coverage to its members. (Completed operations is work performed by a contractor or product manufacturer installing its product.) The RRG may sell insurance in any state without meeting the licensing or other regulatory requirements of any state other than its domicile. No state may discriminate against an RRG, but states may impose normal premium taxes and enforce compliance with unfair claims settlement practices statutes.

The Act is restrictive in that it limits a RRG to products and completed operations coverage, but permits the establishment of a domestic group captive that is able to do business countrywide.

A Purchasing Group ("PG") may be formed to negotiate for a group policy from any insurer to cover product liability completed operations, and commercial general liability when either of the first two coverages are included. The PG and any entity providing services to the PG are exempt from any state law which would prohibit the PG from purchasing this coverage on a group basis.

A group of companies purchasing together presents an attractive premium base with lower administrative costs to the insurer. In a tight market small companies are subject to cancellation or sharply higher prices because an insurer may prefer to use its

resources on a few large risks. The provisions for purchasing groups was necessary to overcome statutes and regulations in about forty-four states which prohibited so called "fictitious groups" set up for the purpose of buying property or casualty insurance on a group basis.

Very few companies have used the RRA to date, but the rapid change in market conditions likely will lead to a much greater interest in its provision.

One reason that the RRA has been little used is the fact that it is limited to products and completed operations coverages, although groups may include other coverages as long as products is the primary purpose. It is a useful means of expanding insurance capacity, and would provide additional capacity in the alternative market if the products limitation were removed.

III. STATE REGULATORY DEVELOPMENTS

State legislators and insurance regulators have recognized the severity of the liability insurance crisis, and have responded in a variety of ways. One state has barred cancellation or non-renewal of policies and prohibited any increases in the cost of policies in effect. Several other states are considering similar actions. The National Association of Insurance Commissioners adopted a resolution opposing mid-term cancellations and short notices of non-renewal. Other states are implementing or considering the use of Market Assistance Programs, which are voluntary assigned risk pools designed to take risks such as day care centers on a rotating or shared basis. Yet other states are considering joint underwriting associations in which the state regulator mandates the sharing of certain risks

Half the states have "file and use" rate regulation in which the insurance department is notified of a rate increase which becomes effective without action by the regulator. Many of these states reportedly are rethinking their systems because of the sharp increases in the rates of some of the problem lines of coverage.

Regulators normally have viewed commercial insurance as transactions between knowledgeable buyers and sellers, and, accordingly, have refrained from interfering with the market's operation. The recent concerns expressed by the Insurance Commissioners is a measure of the depth of the availability/affordability crisis, and may foreshadow a heightening in the regulatory "oversight" of commercial insurance.

CHAPTER 4

TORT LAW REFORM

As discussed in Chapter 2, two primary areas have been the focus of the Working Group's examination into the crisis in liability insurance availability and affordability: the current economic difficulties of the insurance industry; and, the extraordinary growth in tort liability in recent years. For the reasons discussed in Chapter 2, while it seems likely that the insurance industry will be able to work its way out of its present economic straits, it is very unclear -- if not doubtful -- that this will significantly alleviate the crisis in insurance availability and affordability. Early indications are that insurers will continue to avoid areas that present a high risk of tort liability, or, where they do provide insurance, will demand high premiums. That is, while the more extreme aspects of the availability crisis may be resolved once the industry regains its desired level of profitability, it appears unlikely at this time that the high premiums that have led to serious affordability concerns will be reduced significantly.

For these reasons, as well as for the other reasons discussed in Chapter 2, there appears to be little that can or should be done by the federal or any other government to "remedy" the economic factors that underlie the current availability/affordability crisis. The excesses of the tort system, however, present a very real opportunity to address a major cause of the insurance crisis with sensible and appropriate reforms. And while some of the changes in the insurance market currently under contemplation (see Chapter 3) probably will relieve some availability/affordability problems, it seems unlikely that these changes will provide long-term, systemic relief without fundamental reforms of tort law.

The following is a list of eight tort reforms that would bring a greater degree of rationality and predictability to tort law, and thereby significantly assist in resolving the availability/affordability crisis. This is by no means an exhaustive list of possible tort reforms. Nor does the accompanying discussion of these reforms indicate how they necessarily should be implemented; that is, on the federal or state level, or through legislative or judicial modification of the law. Rather, this list identifies eight recommended tort reforms which if implemented should return tort law to a credible fault-based compensation system that provides a fair and reasonable level of compensation to deserving plaintiffs through a more predictable and affordable liability allocating mechanism. While these reforms undoubtedly will be resisted by some, they in fact are quite modest and should not dramatically alter the basic principles of tort law as those have existed for centuries.

Recommendation No. 1: Retain fault as the basis for liability.

For the reasons discussed in Chapter 2, fault should be retained as a basis for tort liability. As noted there, fault is the only mechanism in tort law for distinguishing desirable from undesirable conduct, and is an indispensable predicate to many other aspects of the tort liability system without which the system would generate arbitrary and unfair results.

For non-product liability cases, negligence should remain the applicable standard of liability. Strict product liability should under no circumstances be extended outside the traditional area of product injuries. Thus, theories which would apply strict product liability to landlords or to professionals providing services (e.g., pharmacists, architects, etc.) should be strongly resisted and expressly rejected. The trend in some states ^{1/} to extend strict liability doctrines outside the area of product injuries is a highly pernicious development which will significantly undermine the ability of those sectors of our economy to function properly.

Strict product liability in its traditional sense represents a sensible application of fault-based liability to the realities of modern industrial life. The Working Group, accordingly, does not recommend the abolition of strict product liability, provided the doctrine is kept within its traditional bounds. Unfortunately, strict product liability has been subject to extensive abuse that often has had the effect of transforming the doctrine in practice into absolute liability.

The following are the elements of a strict product liability standard which does not present an impossible or unfair burden to plaintiffs in demonstrating fault on the part of defendant-manufacturers, while at the same time not establishing a scheme of absolute liability which simply uses the manufacturer as an insurer for all risks of injury.

- ° Liability should be predicated on the existence of a defect which is found to make the product unreasonably dangerous.
- ° Defendants should only be held liable for uses of a product that are both reasonable and foreseeable. Liability should not be predicated upon unreasonable or unforeseeable alterations of a product that cause the injury, particularly where such alterations are prohibited or warned against. (Alterations, in this regard, can include the failure to provide required and reasonable safeguards, maintenance or inspections.)

^{1/} See in this regard the recent opinion of the California Supreme Court in Becker v. IRM Corp., 38 Cal.3d 454, 698 P.2d 116 (1985), extending strict product liability to landlords.

- ° Manufacturers should not be liable for defects which have been the subject of an adequate warning or which are readily apparent to the reasonable consumer. Manufacturers should only be required to warn with regard to uses of a product that are both reasonable and foreseeable.
- ° Manufacturers should only be held to the state of the art in existence at the time of manufacture of the product. Manufacturers should not be held liable for unknown or unknowable hazards.

The above elements, if applied in a principled manner, should ensure that strict product liability will serve to compensate persons injured as a result of a manufacturer's fault, while preventing that liability doctrine from simply being used as a risk spreading mechanism designed to operate as a product-based insurance scheme.

Recommendation No. 2: Base causation findings on credible scientific and medical evidence and opinions.

One of the most pernicious developments in tort law has been the extent to which causation findings are based on fringe scientific or medical opinions well outside the mainstream of accepted scientific or medical beliefs. Increasingly, juries are asked to make difficult decisions about highly complicated issues of science and medicine. Unfortunately, the personality and demeanor of expert witnesses often may be more critical in making such determinations than decades of evolving scientific and medical investigation and thought.

This problem has resulted in the growing perception that the tort system often is wholly arbitrary in allocating liability in cases involving difficult issues of science and medicine. This is a particularly problematic situation in toxic tort and drug liability cases. 2/

There are a variety of reasons for this problem:

- ° Many judges do not have the training or inclination to understand complicated scientific and medical concepts, and are unwilling or unable to devote the time and energy needed to educate themselves in a complex body of knowledge.
- ° In order not to deprive plaintiffs of their opportunity for compensation, many courts allow plaintiffs to take

2/ For example, see the discussion of Johnson v. American Cyanamid Co., infra.

whatever scientific or medical views they may have -- however incredible -- to the jury.

- ° Many in the legal system do not appreciate how credible scientific and medical views develop, and the degree to which legal decisionmaking is a poor vehicle for developing such views.
- ° There often is an understandable frustration with the fact that science and medicine frequently cannot offer the kind of certainty that the legal decisionmaking mechanisms strive to obtain.

The inability of the tort system to deal credibly with complicated scientific and medical issues strikes at the very heart of the ability of tort law to deal with the growing number of cases involving highly complicated scientific and medical issues. While there are no easy answers, there are several remedial actions that the Working Group recommends:

- ° Greater deference must be paid to government agencies and certain private institutions that have devoted decades of attention and millions of dollars to researching and trying to assess the value of medical and scientific developments. Where such agencies and institutions have determined that particular products, services or techniques are safe or socially beneficial, courts should tread very carefully in overruling those judgments through the vehicle of tort law. Lay juries are a very poor mechanism for second-guessing the judgment of established mainstream scientific and medical views. Other legal mechanisms for determining those views, such as rulemaking and licensing proceedings, generally are far superior in making credible determinations involving complicated issues of science and medicine.
- ° Courts must be more aggressive in determining the credibility of scientific and medical evidence and opinions before trial, and not simply allow parties to present any theory to the jury. Appellate courts, in turn, should give trial courts greater latitude in making such decisions in early stages of litigation. Judges, where feasible, should receive training on basic methods of scientific, medical and statistical analysis so that they can make such determinations. If necessary, impartial masters with appropriate training should be used for this purpose.
- ° Studies and opinions that have not been subjected to the peer review process should be presumed invalid. Where peer review has taken place, judges (or masters, where appropriate) should acquaint themselves with the results of such review.

° Courts must learn to accept the reality of uncertainty. They must understand that the fact that some degree of uncertainty always exists does not mean that every scientific or medical belief is as credible as the next. Judges and legislators must not try to "force" scientific certainty where such certainty simply is not possible. Attempts to do so through burden-shifting, presumptions or by requiring agencies to issue scientific "findings," simply create a misleading and deceptive gloss of scientific certainty that in fact does not exist. 3/ Ultimately, the legal system must accept the fact that some things are unknown, and, given existing methods and data, perhaps unknowable for the foreseeable future.

Recommendation No. 3: Eliminate joint and several liability.

One of the most troubling problems in tort law arises from injuries caused by multiple tortfeasors. Historically, such cases were handled by bringing separate actions against each defendant; joint and several liability only existed where concert-of-action was shown (see discussion in Chapter 2). Further, under the doctrine of contributory negligence, a negligent plaintiff could not recover damages from any defendant. Such an approach seemed harsh where plaintiffs were only minimally at fault for their own injuries. Eventually, and in part to remedy the harshness of the old rule, the doctrines of comparative fault and joint and several liability were developed to make it easier for plaintiffs to obtain compensation.

Comparative fault operates to assure that each party, including the plaintiff, is liable for its own fault. Joint and several liability, although originally applied to situations where concert-of-action was shown, is now in many cases applied to all defendants, regardless of their connection to the injury. Comparative fault, when coupled with the doctrine of joint and several liability, allows plaintiffs to recover the entire judgment from "deep pocket" defendants -- even if such defendants are only found to be minimally at fault. Joint and several liability thus frequently operates in a highly inequitable manner -- sometimes making defendants with only a small or even de minimis percentage of fault liable for 100% of plaintiff's damage. Accordingly, joint and several liability in the absence of concerted action has led to the inclusion of many "deep pocket" defendants such as governments, larger corporations, and insured entities whose involvement is only tangential and who probably would not be joined except for the existence of joint and several liability.

3/ As noted, the Working Group does not believe that scientific uncertainty can be handled simply by requiring government agencies to issue pronouncements of risk or causation for which there in fact is no credible basis.

Another problem area is the relationship of joint and several liability to "enterprise" or "market share" liability. See Sindell v. Abbott Laboratories, 26 Cal.3d 588, 607 P.2d 924, cert. denied, 449 U.S. 912 (1980). In theory, "market share" liability such as that established in the California Supreme Court's seminal opinion in Sindell attempts to allocate liability for a generic product (e.g., DES) among various producers on the basis of their share of the relevant market. Even assuming such an allocation is reasonable, 4/ some jurisdictions have devised variations of or alternative approaches to Sindell which apply joint and several liability among the producers of a generic product. 5/ See, e.g., Abel v. Eli Lilly & Co., 418 Mich. 311, 343 N.W.2d 164, cert. denied, 105 S.Ct. 123 (1984); Collins v. Eli Lilly Co., 116 Wis.2d 166, 342 N.W.2d 37 (1984). 6/ The difficulties plaintiffs face in attempting to show which manufacturer of a generic product was responsible for plaintiff's injury in fact can be (but are not always) substantial. While the Working Group does not advocate one approach over another, it firmly believes that any allocation of liability on the basis of market share should limit a manufacturer's liability to its specific share, and that such liability should not, in the absence of actual concerted action, be joint and several in nature.

The Working Group thus recommends elimination of joint and several liability, except in the limited circumstances where the plaintiff can demonstrate that the defendants have actually acted in concert to cause plaintiff's injury. 7/

4/ Because of a number of problems and inequities associated with Sindell, only a few states have embraced the position of the California Supreme Court. See Schwartz & Mahshigian, "Failure to Identify the Defendant in Tort Law: Towards a Legislative Solution," 73 Calif. L. Rev. 941 (1985).

5/ It is unclear whether even Sindell is a true "market share" allocation decision, since under Sindell plaintiff must only sue manufacturers representing a substantial share of the market, and may allocate all liability among those defendants in proportion to their respective market shares.

6/ Particularly disturbing are decisions such as Abel which appear to distort the principles of concerted action to impute concerted action to manufacturers of a generic product.

7/ Joint and several liability as discussed in this report should not be confused with the legislatively enacted schemes for allocating financial responsibility for the cost of cleanup of hazardous waste sites and spills under the Nation's environmental laws, and, in particular, under the Superfund Act
(CONTINUED)

Recommendation No. 4: Limit non-economic damages to a fair and reasonable amount.

Non-economic damages such as pain and suffering, mental anguish and punitive damages are inherently open-ended. ^{8/} They are entirely subjective, and often defy quantification. For example, in many instances it simply is not possible, no matter how much money is awarded, to compensate someone fully for the pain and anguish of the loss of a loved one or from a serious injury. Moreover, because such damages are essentially subjective, awards for similar injuries can vary immensely from case to case, leading to highly inequitable, lottery-like results. Accordingly, such damages are particularly suitable for a specific limitation.

The open-ended nature of such damages makes them a particular problem from the standpoint of achieving predictability. Unlike economic damages (medical expenses, lost earnings, etc.), which can be reviewed objectively and thus can be predicted within a given range, non-economic damages are entirely subjective and unpredictable.

Non-economic damages also can serve as a significant obstacle in the settlement process. Plaintiffs and defendants often can

7/ (FOOTNOTE CONTINUED)

(the Comprehensive, Environmental Response, Compensation and Liability Act of 1980) and the Resource Conservation and Recovery Act (RCRA). Unlike the tort system, which is intended to compensate injured persons and to deter wrongful conduct (see Chapter 2), Superfund and RCRA represent a legislative choice to allocate the cost of these programs among those who contributed to the problems the programs are designed to remedy. Thus, Superfund and RCRA liability, like the liability established under other environmental laws, are founded upon congressional objectives which provide that those who contributed to the problem or profited from the manufacture which created the waste, ought to bear the cost of cleaning it up. Those whose specific contribution to the site can be identified and severed from the whole are not jointly liable under this scheme. Without some degree of joint and several liability under Superfund and RCRA, the effective enforcement of these programs could be seriously impeded as a result of protracted and costly litigation among responsible parties over the precise allocation of cleanup costs.

^{8/} There are two types of non-economic damages: compensatory (pain and suffering, mental anguish, etc.) and punitive (sometimes called exemplary damages). The latter are designed purely to punish the defendant.

agree quickly on the amount of economic damages, but disagree sharply on non-economic damages. Plaintiffs frequently have unrealistic expectations of non-economic damages in the hundreds of thousands or millions of dollars to which defendants simply are unwilling to agree. Plaintiffs thus often reject settlement offers that from the standpoint of compensation for economic damages are quite reasonable. Plaintiffs' attorneys also often see high non-economic damage awards as necessary to justify high contingency fees, which may lead them to press for a high non-economic damage award when it may be in their clients' interest to obtain a quick and fair settlement.

Nevertheless, plaintiffs should be entitled to reasonable compensation for their pain and suffering and mental anguish. The key in this regard is to provide such compensation, but to ensure that it will be kept within reasonable bounds.

The Working Group believes that \$100,000 would be such a reasonable limitation. In this regard, it should be noted that only a handful of claims involve non-economic damages in excess of \$100,000. For example, it is estimated that only 2.7% of all medical malpractice claims (5.6% of all paid medical malpractice claims) receive non-economic compensation in excess of \$100,000. ^{9/} However, in those medical malpractice cases going to verdict where non-economic damages above \$100,000 are awarded, the non-economic damages award averages between \$428,000 and \$738,000 (the latter figure being the "best estimate"). ^{10/} For such awards including non-economic damages in excess of \$100,000, on the average 80% of the total award is for the non-economic damages component of the award. ^{11/} Since the non-economic damages in excess of \$100,000 awarded in these cases (including verdicts and settlements) account for between 28% and 50% of all paid out medical malpractice damages, the non-

^{9/} H. Manne, Medical Malpractice Policy Guidebook 132-48 (1985). In comparison, approximately half of all claims that end in a jury verdict in favor of plaintiff include a non-economic damages award in excess of \$100,000. Id. This suggests that non-economic damages are a major factor in forcing claims to trial.

As discussed in Chapter 2, the Guidebook was prepared for the Florida Medical Association. Henry Manne served as the general editor, and the analysis on the effect of a \$100,000 cap was prepared by Patricia Danzon -- "perhaps the most widely known and published economist in the country on the subject of medical malpractice." Id., at 10.

^{10/} Id.

^{11/} Id. In this regard, it is worth noting that non-economic damages as a percentage of overall damages increases substantially as the overall damages increase. Id., at 138-39. See discussion in Chapter 2.

economic damages payments in excess of \$100,000 alone account for up to half of all medical malpractice damages. ^{12/} Thus, a \$100,000 limitation on non-economic damage awards would affect only a relatively small percentage of all claims, but would introduce substantial predictability into the tort system. ^{13/}

It also is necessary to deal with punitive damages. While some thought was given to an absolute ban on punitive damages, or perhaps a separate limitation, the Working Group concluded that the best approach would be to include punitive damages within the \$100,000 limitation on all non-economic damages. Nevertheless, punitive damages should only be awarded for willful conduct bordering on a criminal violation. Specifically, the Working Group recommends that an award of punitive damages be predicated on a demonstration of actual malice.

Even if these recommendations are adopted, punitive damages at best have a tenuous basis in tort law. Increasingly, there has been growing skepticism among legal scholars about the role of punitive damages, ^{14/} and numerous instances of extraordinary

^{12/} Id. The best estimate of the Guidebook is that pain and suffering awards above \$100,000 account for nearly 39% of all medical malpractice damages.

^{13/} Some states have struck down such limitations on constitutional grounds, primarily on the basis of equal protection, on the theory that it is unfair to limit the recoveries of certain plaintiffs (e.g., medical malpractice claimants) while allowing other plaintiffs to receive unlimited recoveries. Recently, however, both the California Supreme Court and the Court of Appeals for the Ninth Circuit upheld such a limitation for medical malpractice verdicts awarded under California law. See Fein v. Permanente Medical Group, 38 Cal.3d 137, 695 P.2d 665 (1985); Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985). The Supreme Court refused to hear either case, finding with regard to the former that no substantial federal question was presented. Constitutional concerns such as this, however, can only be sensibly considered in the context of specific legal proposals.

^{14/} See, e.g., Owen, "Problems in Assessing Punitive Damages Against Manufacturers of Defective Products," 49 U. Chi. L. Rev. 1 (1982); Seltzer, "Punitive Damages in Mass Tort Litigation: Addressing the Problems of Fairness, Efficiency and Control," 52 Fordham L. Rev. 37 (1983); Sugarman, "Doing Away With Tort Law," 73 Calif. L. Rev. 555 (1985); Schwartz, "Deterrence and Punishment in the Common Law of Punitive Damages: A Comment," 56 S. Cal. L. Rev. 133 (1982); Ellis, "Fairness and Efficiency in the Law of Punitive Damages," 56 S. Cal. L. Rev. 1 (1982).

abuses. 15/ Punitive damages add considerable uncertainty, and frequently have very little real deterrent effect because they are awarded years after the offending conduct. In any event, the punishment of misconduct is primarily a function of the public law enforcement system, and should not be a common purpose of private litigation.

Nevertheless, the Working Group does not recommend prohibiting punitive damages in tort cases provided they are included within the limitation on non-economic damages. If this is infeasible, the Working Group recommends that punitive damages be abolished. 16/

Recommendation No. 5: Provide for periodic payments of future economic damages.

Traditionally, a losing defendant is required to pay all of plaintiff's future damages in one lump-sum payment. When damages were within reasonable limits, this generally was not a major problem. But as average damages have skyrocketed into the hundreds of thousands of dollars this has become an increasing burden on the defendant (or defendants' insurers). The Working Group, therefore, recommends that future economic damages be paid periodically. 17/

Allowing defendants to pay for plaintiff's damages periodically has several advantages. First, it gives defendants the ability in some cases to digest major adverse judgments by spacing

15/ One of the most flagrant examples is the \$8 million dollar punitive damage award against the defendant in Johnson v. American Cyanamid Co., (District Court No. 81 C 2470), for its decision to produce the Sabin rather than the Salk polio vaccine. Despite the fact that the defendant had complied in this decision with the well established medical judgment of the United States government and virtually the entire medical community, the jury apparently decided to use punitive damages to overrule this judgment and to force the Sabin vaccine off the market. Ironically, the Sabin vaccine has proven far more effective than the Salk vaccine in combating polio. The case presently is on appeal to the Kansas Supreme Court, and the federal government has filed an amicus brief urging reversal.

16/ It frequently is noted that the deterrent effect of punitive damages could be achieved through a system of civil fines.

17/ Where there is legitimate concern that a particular defendant may not be able to make the periodic payments in future years the court should be empowered to require the defendant to ensure the periodic payment through the purchase of an annuity.

payments out over time, much in the same way that many consumers can afford major purchases by buying on installment. Second, society is benefited by the fact that plaintiffs have a guaranteed stream of income, and cannot deplete their awards within a few years. This sharply reduces the possibility that severely injured plaintiffs eventually will become wards of the state.

An important additional advantage of requiring courts to award damages in terms of periodic payments rather than lump-sum awards is that it uses the market's rather than a court's assessment of the applicable interest rate. Under the existing practice in most states, the trial court determines plaintiff's economic loss over plaintiff's lifetime, and then awards plaintiff the present value of those losses in a lump sum. The interest rate used to make that present value calculation is critical, and can significantly reduce or inflate the lump-sum payment. Frequently, courts in making that calculation use interest rates that bear no reasonable relationship to what in fact is available in the market.

A periodic payment requirement effectively avoids this problem by having the court determine the stream of future economic losses and require defendant to purchase an annuity providing a corresponding stream of compensation (where defendant is sufficiently large, an actual annuity probably would be unnecessary). Under such a procedure, the market determines the appropriate interest rate for calculating the present value of those payments (the present value would equal the cost of the annuity). Since the payments are guaranteed through the annuity, subsequent changes in the interest rate would have no effect on plaintiff's compensation. Defendant, on the other hand, would have the market rather than a judge or jury determine the correct interest rate for assessing the present value of future damages.

Periodic payments, as noted, are not unfair to plaintiffs because the payments would be scheduled to be made as the damages are in fact incurred (that is, as earnings are actually lost, or as certain expenses actually occur).

Because the benefits of such a provision would be relatively limited for smaller awards, the Working Group recommends that periodic payments only be required where the total economic damages award exceeds \$100,000.

Recommendation No. 6: Reduce awards by collateral sources of compensation for the same injury.

The collateral source rule prohibits the finder of fact from taking collateral sources of income related to the same injury into account in making an award of damages to the plaintiff. This effectively permits the plaintiff to obtain double recovery of certain components of his damages award.

In an era when collateral sources of income were financed largely by plaintiff himself, the collateral source rule may have been sensible. Today, however, when many collateral sources are provided or subsidized by the government or by third parties (such as employers, who often are required by law to provide certain collateral benefits), the traditional justification is called into question. Increasingly, the collateral source rule simply permits a windfall recovery by the plaintiff.

As to publicly provided collateral sources of compensation, there is no justification for not taking such sources into account in determining plaintiff's ultimate damages. The collateral source rule in such circumstances has the effect of requiring citizens to pay compensation twice -- once as taxpayer, and once as the consumer of the product causing the injury. 18/

The situation is somewhat more complicated in dealing with private sources of collateral compensation, particularly where subrogation is involved. 19/ Where a third party (such as an insurer) is subrogated to plaintiff's claim, the collateral source rule may not in fact result in any double recovery. As a practical matter, however, subrogation often is not a significant consideration in many tort actions. In some areas, such as automobile accidents, subrogation is quite common. In other areas, however, such as medical malpractice, subrogation is far less common.

As to private sources, the best approach appears to be to require collateral sources of compensation related to the same injury to be taken into account as long as a third party is not subrogated to that portion of plaintiff's claim. Further analysis may suggest that elimination of subrogation (that is, simply offsetting all collateral sources against the award, and prohibiting subrogation arrangements) may have a limited effect and be justified on the basis of significant reductions in transaction costs.

While the correct approach to workers' compensation benefits must be considered very carefully, workers should be required to seek their workers' compensation benefits where appropriate. The Working Group takes no position on whether subrogation and indemnification actions between employers and manufacturers

18/ Another reason to be concerned about such a windfall is that much of the windfall is in fact a windfall for attorneys in the form of attorneys' fees.

19/ In the context of insurance, subrogation allows the insurer to obtain from the tortfeasor-defendant all or part of its payments to the insured-plaintiff arising from the injury caused by the tortfeasor.

found liable as third party defendants should be eliminated, as has been proposed in some legislation. The Working Group will continue to review the merits of proposals dealing with such subrogation and indemnification actions.

Recommendation No. 7: Schedule contingency fees.

Currently, plaintiffs' attorneys receive a flat percentage of their clients' awards, usually between 30% and 40%, but sometimes as high as 50%. Where plaintiff's award is moderate, such a contingency fee may, in fact, be quite reasonable, since the attorney has significant costs and may face substantial risks that must be reimbursed. But as the average plaintiff's verdict has increased in recent years, such a high percentage becomes difficult to justify. Increasingly, there are indications of extraordinary abuses where attorneys receive fees in the hundreds of thousands of dollars for limited work. Particularly in mass liability cases where the groundwork for liability has been laid in previous cases by other attorneys, the fees often bear no relationship whatsoever to the work of or the risk to plaintiff's attorney. 20/

Nevertheless, the Working Group does not recommend, as some have suggested, the abolition of contingency fees. Often, such fees are the only means available to the poor to afford an attorney and obtain access to the legal system. The problem with contingency fees emerges when awards become very high, and a flat contingency rate becomes excessive. The Working Group, therefore, believes that contingency fees should be scheduled to decrease as awards increase.

Specifically, the Working Group recommends the following schedule: 25% for the first \$100,000, 20% for the next \$100,000, 15% for the next \$100,000, and 10% for the remainder. Thus, for an award of \$500,000, plaintiff's attorney would receive \$80,000 rather than \$166,666 (assuming a one-third contingency fee), and for an award of \$1,000,000, would receive \$130,000 rather than \$333,333.

There are a number of justifications for scheduling contingency fees:

- ° Verdicts often are inflated by judges and juries to compensate plaintiff for what is well understood to be high attorneys' fees. Defendants thus pay for such fees through higher insurance premiums or awards,

20/ As discussed in Chapter 2, the prevailing plaintiff is not only liable to his attorney for the agreed to contingency fee, but also for litigation expenses. Such expenses often can amount to an additional five to eight percent of the underlying award.

found liable as third party defendants should have been proposed in some legislation. The committee continues to review the merits of proposals for subrogation and indemnification actions.

Recommendation No. 7: Schedule contingency

Currently, plaintiffs' attorneys receive a percentage of their clients' awards, usually between 30% and sometimes as high as 50%. Where plaintiff attorneys charge such a contingency fee may, in fact, be quite high if the attorney has significant costs and may face risks that must be reimbursed. But as the size of verdicts has increased in recent years, such a contingency fee becomes difficult to justify. Increasing indications of extraordinary abuses where awards in the hundreds of thousands of dollars for a single plaintiff. Particularly in mass liability cases where liability has been laid in previous cases, the fees often bear no relationship whatsoever to the risk to plaintiff's attorney. 20/

Nevertheless, the Working Group does not believe that, as suggested, the abolition of contingency fees and the use of flat rates are the only means available to the poor to obtain access to the legal system. The problem of contingency fees emerges when awards become large and a flat contingency rate becomes excessive. The Working Group therefore believes that contingency fees should decrease as awards increase.

Specifically, the Working Group recommends the following schedule: 25% for the first \$100,000, 20% for the next \$100,000, 15% for the next \$100,000, and 10% for the remainder. Thus, for an award of \$500,000 the plaintiff would receive \$80,000 rather than \$166,666 (25% contingency fee), and for an award of \$1,000,000 the plaintiff would receive \$333,333 rather than \$333,333.

There are a number of justifications for such a schedule:

- ° Verdicts often are inflated by attorneys to compensate plaintiff for what is often high attorneys' fees. Defendant attorneys reduce their fees through higher insurance payments.

20/ As discussed in Chapter 2, the plaintiff is not only liable to his attorney for the fee, but also for litigation expenses. The amount of the fee amounts to an additional five to eight percent of the award.

a rule would significantly deter frivolous litigation may be largely illusory.

A preferable (but still problematic) alternative approach to the English Rule would be to use a transfer of attorneys' fees as a means of motivating parties to settle their claims at an earlier point in litigation. Thus, a rule modeled on Rule 68 of the Federal Rules of Civil Procedure, 21/ but including attorneys' fees, might be useful. Perhaps the most promising approach would be to combine alternative dispute resolution with a transfer of attorneys' fees.

Recommendation No. 8: Develop alternative dispute resolution mechanisms.

The Working Group believes that alternative dispute resolution holds much promise. Experimentation and experience, however, is the only reliable vehicle for determining which systems will work. Alternative dispute resolution proposals range from binding arbitration to mediation, and include such procedural innovations as mini-trials and expedited discovery techniques. Many of these proposals are worthy of serious consideration, and states represent excellent laboratories in which to develop and explore these various alternative dispute resolution proposals.

The Working Group strongly supports alternative dispute resolution, and believes that the organized bars, legislatures, and jurists should be more receptive to alternative dispute resolution proposals. Where necessary, particularly in areas such as medical malpractice, states should be encouraged to consider seriously the necessary constitutional changes to permit the use of alternative dispute resolution.

The Working Group believes that the most promising use of alternative dispute resolution will be to encourage the early settlement of lawsuits. For example, requiring non-binding arbitration where part or all of attorneys' fees shift to the party which rejects an arbitration award and obtains a less favorable result in litigation, much as costs of litigation are shifted for rejected offers of settlement under Federal Rule of Civil Procedure 68 (see supra), might be an effective means

21/ Rule 68 ("Offer of Judgment") provides that costs of litigation will shift to a plaintiff who has rejected an Offer of Settlement made under the rule and not obtained a judgment more favorable than the rejected offer. There currently is a proposal under consideration to include attorneys' fees in Rule 68, as well as to make other changes to the Rule. Inclusion of attorneys' fees in Rule 68, however, has a number of serious problems that must be considered very carefully. These and other problems have led the Department of Justice to caution against the proposed changes to Rule 68.

for using alternative dispute resolution to facilitate and expedite early settlements.

The Working Group does not believe, however, that alternative dispute resolution needs to or should involve major changes to the standards of liability or causation in tort law. The merits of alternative dispute resolution are largely unrelated to which standard of liability is used in resolving disputes. The value of alternative dispute resolution lies in procedural rather than substantive changes in the law.

CHAPTER 5

GOVERNMENT INSURANCE: A NON-SOLUTION

The growing liability insurance availability/affordability crisis has spawned calls for government insurance or indemnification for persons or companies unable to obtain adequate insurance coverage through the private sector. For the reasons discussed below, such government insurance or indemnification would be highly undesirable and would do nothing to remedy the problems underlying the availability/affordability crisis.

The most serious deficiency with the various schemes for government insurance or indemnification is, as noted, the fact that such proposals do not address the problems that have led to the availability/affordability crisis. Instead, these schemes simply would pass the costs of the crisis directly to the taxpayer. While it is difficult to estimate the potential cost of such a program to the American taxpayer, it should be noted that the insurance industry suffered an estimated \$25 billion underwriting loss in 1985 (see Chapter 2). This loss does not include self-insurance or captive insurer losses, which in all likelihood represent additional billions of dollars.

A government insurance or indemnification program would by definition certainly involve the riskiest activities; that is, those activities that even the insurance industry is unwilling to underwrite. To the extent that the government attempts to address affordability problems by offering coverage more cheaply than the industry, the government, of course, simply would be subsidizing certain purchasers of insurance. Again, the cost of such subsidization is difficult to estimate, but considering that the insurance industry paid out over \$126 billion in 1985, with related expenses of \$37 billion (see Chapter 2), such a subsidy easily could involve tens of billions of dollars annually. ^{1/} (Again, these figures do not include self-insurance or captive insurers).

Government insurance or indemnification would not only pass these costs to the taxpayer, but could exacerbate the current problems of the tort system. One of the few constraints left in tort law is the recognition that "deep pockets" are not after

^{1/} For example, over recent years the National Flood Insurance Fund has been subsidizing flood insurance by roughly \$150 million annually. The cumulative loss for the program to date is approximately \$1.4 billion. The President, in his latest budget submission, reiterated his intention to continue to phase out this costly subsidy. The riot insurance program, which existed from 1968 to 1984, was able to sustain itself through collected premiums. The relative success of the program, however, was largely due to the decline in urban riots after the program was instituted.

all bottomless -- that there is a finite amount of resources that can be reallocated through tort liability. Government indemnification or insurance would remove that last restraint, since the resources of the Federal Government are all too often viewed as without limit. Thus, courts and juries might be even more willing to skew liability and causation standards to ensure compensation, and to award the most generous compensation conceivable.

There are, however, a number of compelling reasons for rejecting the concept of government insurance or indemnification other than because of its potential cost and the failure to address the real problems underlying the crisis. Perhaps foremost among those reasons is that such a program would most likely jeopardize among the most effective and important mechanisms currently existing in the private sector to protect public health and safety. The insurance industry plays a vital role in promoting public health and safety by policing insureds to ensure that risks of injury are minimized. Insureds who fail to minimize such risks, or who experience higher than normal claim rates, may find the desired level of insurance coverage more difficult to obtain and more expensive. The insurance industry thus plays an important role in creating incentives that protect public health and safety, both in policing insureds, and in passing the benefits of safety back to the insureds through lower premiums.

While the role of insurance in promoting public health and safety is by no means perfect, and the above description admittedly is somewhat idealized, insurance creates important health and safety incentives which cannot be dismissed lightly. This critical function of insurance is undermined to the extent that the government supplants the private sector in providing insurance or indemnification, particularly for high risk activities. The government, even if and when it demonstrates the best of intentions, simply does not have the resources, experience, flexibility or incentives to replicate the activities of the private sector in policing insureds' practices and setting premiums to reflect claims experience. In addition, were the government to undertake such activities, the existing health and safety bureaucracies almost certainly would prove inadequate. Substantial additional funds, personnel and resources would need to be devoted to these activities, and in many areas new bureaucratic structures would need to be established. 2/ If, as seems likely, such additional investments of government resources are not made, government insurance or indemnification would operate as a clear disincentive to greater safety since insureds would receive

2/ The necessary collection and analysis of relevant information would of itself be a major undertaking requiring substantial investment of additional government resources.

the benefit of a risk transfer to the government (and, accordingly, would have less incentive to protect public health and safety) without any corresponding checks upon their conduct or activities. Both the consumer and the taxpayer would be the ultimate losers.

To the extent that the government institutes an insurance or indemnification program, such a program also would increase significantly in two ways the involvement of the government in the private sector. First, while the government, as noted, cannot replicate the efforts of the insurance industry, it would have to become involved in the activities it has insured or indemnified to ensure that such insurance or indemnification does not lead to completely open-ended liability on the part of the government. This necessarily would involve new additional forms of government supervision and regulation of private sector activities.

A second undesirable but inevitable effect of such a program would be that the government frequently would be forced to manage, or at least actively oversee, the litigation of cases involving the liability of its insureds, since the insureds often would have only a limited incentive to contest aggressively claims, however meritless, against which they are fully insured or indemnified. Even putting aside the consideration of the massive investment of litigation resources that would be needed by both the insuring agencies and the Department of Justice, this could involve the government directly and actively in some of the most controversial and visible tort litigation in our society, much of which would involve litigation in state court under substantive, procedural and evidentiary rules of state law.

An additional consideration is that such a program necessarily would involve the federal government in state regulation of the insurance industry since such regulation could have a significant impact on the kind of insurance or indemnification the federal government would have to provide. For example, state regulators who might wish to avoid approving politically unpopular rate increases or policy provisions might be far more inclined to withhold such approvals if they perceived the federal government as ready and willing to provide an alternative source of insurance. The federal government, in turn, in order to avoid such wholesale transfers of the insurance burden, could very easily find itself compelled to regulate the insurance industry directly, or to regulate the state regulators. Either way, it would represent a substantial intrusion by the federal government into the regulation of the insurance industry.

Finally, a federal program of insurance or indemnification would interfere with and perhaps severely inhibit the ability of the market to devise new policies, insurance mechanisms, and specific contractual provisions to meet changing economic and

social conditions. Where the current services of the insurance industry prove inadequate or unacceptable, insurers and insureds have strong incentives to restructure those services so that the needs of the marketplace can be met (witness, for example, the current discussions over the introduction of claims-made policies and the inclusion of defense costs). Where government insurance or indemnification is available, however, insureds may be far more inclined to seek such insurance (particularly where it is subsidized, either intentionally or unintentionally) than to negotiate with insurers or invest considerable effort and resources shopping for better conditions. Insurers, in turn, who may feel themselves compelled to offer otherwise unattractive services to customers they wish to retain, may find a government insurance or indemnification program a convenient dumping grounds for the risks they would rather spin-off. 3/ The end result could very well be that the ability of the marketplace to respond to new conditions with innovative solutions could be severely chilled if the "safe harbor" of government insurance or indemnification were available to both the insureds and the insurers. 4/

In sum, government insurance or indemnification would be a highly undesirable and counterproductive response to the current availability/affordability crisis. It effectively would amount to the nationalization of a potentially large portion of one of the Nation's leading financial industries. And, given the history of past government involvement in the private sector, it is all too apparent that removing the federal government from the insurance industry once the purported justification for its presence had passed would be an arduous if not ultimately futile endeavor.

3/ Such risks most likely would include the type of long-latency, catastrophic risks endemic to toxic torts. As is apparent from the asbestos litigations, such insurance would expose the taxpayer to potentially massive liability. The problem of insurers spinning off certain types of business very likely would generate pressure for some form of federal regulation of such practices.

4/ It should be noted in this regard that the contractor indemnification provision which the Administration supports in the context of Superfund reauthorization is purely discretionary in nature, is limited to cleanups under the control of the Environmental Protection Agency, is linked to a critical limitation on liability (liability would be predicated only on negligence), and would be provided only because it will be extremely difficult, if not impossible, to keep this vital program in operation without such limited and closely regulated contractor indemnification (which presumably will include both limits and deductibles).

CONCLUSION

This report contains within it a number of observations, conclusions and recommendations. The most important of these, however, for the purposes of the Tort Policy Working Group, are what this report implies as to the appropriate response of the federal government to the current crisis in insurance availability and affordability. In this regard, the pertinent conclusions are straightforward and relatively apparent.

First, tort law appears to be a major cause of the insurance availability/affordability crisis.

Second, there are a number of beneficial reforms of tort law that the federal government can support and promote in sensible and appropriate ways.

Third, to the extent that other factors -- such as the recent large underwriting losses of the insurance industry -- underlie this crisis, there is little the federal government can or should do to remedy these problems. While the contribution of these economic factors seems clear, it is likely that these problems will work themselves out in the short-term as the insurance industry restores its desired level of profitability, and as other insurance industry developments (see Chapter 3) are implemented. It seems highly unlikely, however, that these changes will substantially alleviate the crisis, particularly the affordability aspect of the crisis, without substantial reforms of tort law.

Fourth, the Working Group found nothing to support the suggestion that this crisis could be remedied through federal regulation of the insurance industry or of state insurance regulators.

Fifth, while a federal insurance or indemnification program obviously could provide subsidized insurance where insurance is unavailable or unaffordable, for many reasons (see Chapter 5) such a program would be highly undesirable and ultimately counterproductive.

In sum, tort law appears to be a major cause of the insurance availability/affordability crisis which the federal government can and should address in a variety of sensible and appropriate ways. But significant, long-term reform cannot and should not come solely from the federal government. Ultimately, state governments and courts must address the current excesses of tort law. Their active participation is essential to finding workable solutions to the increasingly debilitating problems of tort law.

An Update on the Liability Crisis

Tort Policy Working Group



March 1987

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**INTRODUCTION
AND
EXECUTIVE SUMMARY**

In February of 1986 the Tort Policy Working Group issued a report entitled "Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability."¹ As its title indicates, the Report not only documented the existence of the crisis in insurance availability and affordability, but analyzed its various causes and made a number of appropriate policy recommendations.

The following is an update on that Report. It not only updates the Working Group's prior Report in the sense of reviewing the past year's developments as to both the insurance crisis and tort law (and, most importantly, tort reform), but it also summarizes and analyzes recently published empirical data on our Nation's tort system. In addition, it discusses new issues and questions relating to the liability crisis which have emerged in the course of the national debate during 1986 over the problems and the future of our civil justice system.

Chapter 1 of the Report (An Update On the Availability and Affordability of Liability Insurance) summarizes the current state of insurance availability and affordability in the United States. It indicates that while availability problems have substantially ameliorated since a year ago, they continue to exist in certain lines or types of coverage, where they remain serious. Affordability problems also have ameliorated, but only in the sense that premiums appear to have stabilized at much higher levels. This increased availability and price stability has been accompanied by, and in no small part is a result of, the use of higher deductibles, lower coverage limits and additional policy exclusions and limitations. Moreover, the past year has witnessed an increasing reliance on both self-insurance and captive insurer programs, though it remains to be seen whether such arrangements provide reliable long-term insurance coverage. Most importantly, the Chapter shows that, despite some assertions to the contrary, the impact of the crisis in insurance availability and affordability continues to be felt -- often acutely -- throughout much of the American economy.

¹ The Tort Policy Working Group consists of senior Administration officials of eleven federal agencies, seven of whom serve as the chief legal officer of their agency.

Chapter 2 of the Report (The Insurance Industry's Economic Performance) updates the Working Group's prior analysis of the economic state of the property/casualty insurance industry. It indicates that the industry's profitability in 1986 improved markedly from 1984 and 1985, although its 1986 rate of return was roughly equivalent to its ten-year average, and was slightly less than the ten-year rate of return for Fortune 500 industrial corporations. The Chapter also shows that the two key lines that have been central to insurance availability and affordability problems -- Commercial General Liability and Medical Malpractice -- continue to generate disproportionately high underwriting losses. These two lines produced 13% of the industry's written premiums in 1986, but accounted for 33% of the industry's total underwriting loss. The Chapter also briefly discusses the fact that while the industry's profitability has varied cyclically, the industry's economic downturn in the mid-1980's was far more serious than its downturn in the mid-1970's.

Chapter 3 (The Contribution of Tort Law to the Crisis in Insurance Availability and Affordability) addresses a number of different issues relating to our tort system. Part I of the Chapter (Jury Awards) analyzes data recently published by the Rand Corporation's Institute for Civil Justice on jury award trends in Cook County, Illinois and San Francisco from 1960 through 1984. The Institute's data, which are inflation-adjusted, show that during this period the average jury malpractice award increased by 2,167% (from \$52,000 to \$1,179,000) in Cook County and 830% (from \$125,000 to \$1,162,000) in San Francisco. The comparable increase in average jury product liability awards was 212% (from \$265,000 to \$828,000) in Cook County and 1,016% (from \$99,000 to \$1,105,000) in San Francisco.

Even more astounding is the increase in the "expected jury award" -- the average jury award multiplied by plaintiff's likelihood of success. From 1960 to 1984, the expected jury malpractice award (also inflation-adjusted) increased by 4,254% (from \$13,000 to \$566,000) in Cook County and 1,172% (from \$34,000 to \$616,000) in San Francisco. The comparable increase in expected jury product liability awards was 445% (from \$76,000 to \$414,000) in Cook County and 927% (from \$56,000 to \$575,000) in San Francisco.

It is interesting to note that both the average jury award and expected jury award data show that most of the increase in jury verdicts from 1960 to 1984 occurred during the 1980 to 1984 period. For example, in many of the categories, the increase in awards from 1960 to 1984 was double or triple the entire increase in jury awards from 1960 to 1980.

The Institute's data also show a very substantial increase in inflation-adjusted million-dollar jury awards. Of particular

interest is the fact that million-dollar awards accounted for 85% of the total damages awarded by Cook County juries in 1980 to 1984 (as compared to 4% in 1960 to 1964) and 58% of the total damages awarded by San Francisco juries during the same period (as compared to 14% in 1960 to 1964). Thus, a small percentage of all tort cases appears to account for a very large percentage of the total tort damages awarded by juries.

Part II of the Chapter (Case Filings) addresses a number of arguments that have been raised regarding the Working Group's evidence of substantial growth in product liability and medical malpractice cases filed in federal court. The Chapter discusses the recent study of the National Center for State Courts, which has been widely cited for the proposition that there is no "litigation explosion" in the United States. Part II not only identifies a number of serious methodological deficiencies in the Center's study, but notes that because the Center's study aggregates all tort filings -- including automobile accident cases -- it cannot and does not provide any meaningful insights as to the growth in the type of complex tort litigation, such as product liability, medical malpractice and many municipal liability cases, that have been at the center of the debate over tort reform.

Part II also answers a number of assertions that have been made regarding the methodology and meaning of the federal district court caseload data compiled by the Administrative Office of the United States Courts.

Part III of the Chapter (Punitive Damages) discusses the most recent data collected by the Institute for Civil Justice on punitive damage awards. It also notes the growing consensus within the legal community that punitive damages have become a source of substantial litigation abuse, and discusses a number of reasons why punitive damages need to be reformed. Of particular importance is the fact that punitive damages not only exacerbate insurance availability and affordability problems, but that they often serve as a significant obstacle to settlement, even where the likelihood of a punitive damage award is relatively small.

Part IV (Transaction Costs) discusses data recently published by the Institute for Civil Justice on the overall transaction costs of the tort litigation system. The data show, for example, that out of a total tort litigation expenditure in 1985 of \$29 to \$36 billion, plaintiffs received at most \$14 to \$16 billion. If only non-automobile tort cases are considered, the net compensation paid plaintiffs amounted to only 43% of the system's total expenditures.

Part V of the Chapter (Doctrinal Changes in Tort Law) discusses the fact that many of the current problems of the tort system can be traced to the sweeping doctrinal changes in tort

law embraced by the courts over the past two decades. These doctrinal changes almost universally seem to have shared one common objective -- to increase plaintiff's likelihood of obtaining compensation. As noted in Part V, this has led to a systematic undermining of the most fundamental principles of tort liability -- most importantly, the roles of fault and causation. Part V notes that this judicial attack on the traditional limitations and conditions placed on tort liability has not only had the effect of increasing the amount of tort liability, but has introduced considerable uncertainty and unpredictability into tort law. This uncertainty and unpredictability greatly exacerbates the already serious problems of the tort system, and substantially increases the cost of liability insurance. And, as importantly, the lack of predictability has undermined and perverted the deterrent role of tort law.

Chapter 4 (Public and State Support for Tort Reform) summarizes the remarkable success of tort reform in 1986. It describes the wide-spread popular support for tort reform, as indicated by opinion polls, ballot initiatives, the breadth of many of the coalitions formed to advocate tort reform, and even the support for tort reform from much of the legal profession. The Chapter also describes the National Governors Association's recent unanimous endorsement of product liability reform, as well as the support for tort reform of a number of State Commissions and Task Forces which were directed to analyze the insurance and liability crisis and make appropriate recommendations. In addition, the Chapter summarizes the extraordinary record of tort reform initiatives in the State legislatures in 1986, a year in which over two-thirds of the States enacted tort reform legislation of one sort or another. Finally, the Chapter briefly summarizes the State legislative activity last year relating to insurance regulation.

Chapter 5 of the Report (An Analysis of Various Tort Reform Provisions) analyzes six areas of tort reform which were the subject of considerable legislative activity in State legislatures in 1986. The analysis reviews the strengths and weaknesses of some of the different legislative reform formulations enacted by the States. Where appropriate, the Chapter also sets out the legislative provisions drafted by the Working Group which were part of the Administration's civil justice reform package submitted both last year and this year to the Congress, and explains the reasons for the specific legislative language adopted by the Working Group.

Chapter 6 (The Relationship of Tort Reform to Insurance Availability and Affordability) addresses an issue which has been central to the debate over tort reform -- whether such reforms in fact have a significant effect on insurance availability and affordability. The Chapter explains the reasons why tort reforms take some time to affect the insurance market. But it also notes that there is persuasive evidence that over the long-term tort reforms can have a very substantial impact on insurance. Specifically, the Chapter compares the experience of California physicians, who have the benefit of a rigorous medical malpractice reform statute enacted in 1975, with that of New York and Florida physicians, who practice in States with far weaker medical malpractice reforms. The difference in the experience of California physicians to that of their New York and Florida colleagues is instructive, to say the least. The rate of increase of medical malpractice premiums paid by New York and Florida physicians from 1980 to 1986 was substantially higher than for California physicians; indeed, for high risk specialties such as obstetrics/gynecology and neurosurgery, the rate of increase was two to three times larger in New York and Florida than in California. And the premiums paid by obstetricians/gynecologists in 1985 was substantially less in California than in New York or Florida for similar coverage, both in absolute dollar terms as well as in the percentage of physician net income and physician gross revenue. Accordingly, it seems evident that strong tort reform measures, if given sufficient time, can have a very substantial impact on the insurance market.

The Appendix to the Report provides the results of an economic analysis by the Antitrust Division of the Department of Justice, prepared at the request of the Working Group, of the causes of the crisis in insurance availability and affordability. The analysis reviews the merits of the four most commonly alleged causes of the crisis -- insurer collusion, imprudent insurer business practices and declines in investment income, State insurance regulation, and changes in tort liability. It finds that it is unlikely that any of the first three of these alleged causes in fact caused the crisis. The analysis concludes that only the last alleged cause -- changes in tort liability -- can be directly responsible for the recent availability and affordability problems in property/casualty insurance. Based on its review of the property/casualty industry's financial performance, the Antitrust Division's analysis concludes that two specific aspects of the tort system -- changes in the average awards, and increased uncertainty -- have contributed greatly to the crisis in insurance availability and affordability.

The Conclusion to the Report lists eight conclusions of the Working Group regarding the insurance and liability crisis and the appropriate response of the federal government to that crisis.

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Task Force on Liability
Insurance Availability

March, 1987

CHAPTER 1

AN UPDATE ON THE AVAILABILITY AND AFFORDABILITY OF LIABILITY INSURANCE

In its Report last year, the Tort Policy Working Group documented the existence of a serious crisis in insurance availability and affordability. The Report identified a number of industries, professionals, public entities and other purchasers of liability insurance that were experiencing extraordinary premium increases (often in combination with lower limits and higher deductibles), or, in some instances, were unable to obtain any insurance coverage at all. The Report concluded that there were two primary causes underlying this crisis: the economic difficulties of the insurance industry -- essentially a short-term (but potentially recurring) problem; and, the deteriorating tort system -- a long-term problem which appears to have worsened considerably in recent years. As noted in the conclusion to the Report, "it is likely that these [economic problems of the insurance industry] will work themselves out in the short-term as the insurance industry restores its desired level of profitability, and as other insurance industry developments . . . are implemented."² The Working Group Report also concluded, however, that while this might mean that some unavailability problems would be resolved, insurance premiums would remain high, and affordability problems accordingly would remain a serious and long-term concern.³

The past year has proved that the Working Group's predictions were correct. The insurance crisis has, in fact, ameliorated; that is, premiums appear to have stabilized at now much higher levels, and unavailability problems have limited themselves to specific lines or types of coverage. Much like the oil crisis of the early 1970's following the OPEC oil embargo, after experiencing an initial shock and immediate serious economic dislocations, the public appears to have resigned itself to an era of much higher prices.

It is important to note, however, that stability in prices and greater availability of insurance is not merely the result of the substantial premium increases of the past two years. For one

² See page 80 of the Working Group's Report.

³ Id., at pages 51-52, 60 and 80.

thing, insurers appear to have abandoned certain risks which they have found to be too unpredictable or open-ended to insure with any degree of certainty. In some instances they have abandoned these risks simply by refusing to write coverage; in other instances they have written some coverage, but sharply reduced their exposure through low limits or the use of claims-made policies. All of these latter developments essentially achieve the same purpose -- they force the purchaser of insurance to retain far more risk than it would prefer, thereby limiting the uncertainty faced by the insurer. While this may make insurance available where it otherwise might be unavailable, and bring down the cost of coverage to an affordable level, it means that many risks are either uninsured or inadequately insured.

Moreover, much of the new found stability in premiums, as well as some of the availability of insurance, is the result of recently instituted self-insurance programs. It remains to be seen whether these self-insurance programs will, over the long-term, provide a stable source of insurance that the commercial market is unwilling to offer at affordable prices. If these self-insurance programs should fail, the results may be even more adverse for the United States economy than the most extreme aspects of the recent crisis in insurance availability and affordability. Unfortunately, the experience of the captive insurance companies (widely known as "bedpan mutuals") established by many physicians in the mid-1970's as a result of a crisis in medical malpractice insurance suggests that these efforts, though capable of providing short-term relief, are not always a viable long-term solution.

Finally, as noted, there continue to be serious availability problems in certain lines or types of coverage, particularly in those areas with "long-tail" exposure; that is, where the liability may not manifest itself for many years, perhaps not even for decades. For many of these purchasers of insurance, the crisis has not abated in the least, and may in fact be even more pressing today than a year ago.

The following is an update on the state of insurance availability and affordability.

I. Insurance Coverage Summaries

Year-end reports in the business press note increased capacity and greater availability of liability insurance than existed a year ago. Prices are still high, but the days of triple-digit percentage increases appear to be over. While serious problems remain in certain markets -- environmental coverage, medical malpractice and certain product liability risk

classes -- in general, availability is greater and prices have largely stabilized, albeit at a much higher level.

The National Association of Insurance Commissioners (NAIC) released two availability surveys in December, 1986. The survey of regulators concluded that improvement in availability has occurred overall as well as in several individual liability lines. Lines identified by 25% or more of the responding States as showing great or slight improvement were day care, nurse-midwives, restaurant liquor liability, truckers liability and exterminators liability. However, additional problem areas were identified in the categories of recreational liability exposures, professional liability and product liability.

The following summaries of changes in particular types of liability coverage were derived from reports in the business press and insurer reports.

Environmental Impairment Liability Insurance (EIL) and Sudden and Accidental Pollution Coverage

A recent NAIC survey of State insurance departments found that thirty-seven States reported availability problems with environmental liability. NAIC is currently conducting a study of the environmental liability market.

Most package policies (both Commercial Multiple Peril and Commercial General Liability policies) now specifically exclude pollution risks of all types as part of their comprehensive coverage.

Directors and Officers Liability (D & O)

While availability problems are easing somewhat, D & O liability remains tight according to the NAIC availability survey. Coverage is still not available for certain risks, and desired liability limits may not be available.

Year end reports suggest that D & O coverage is improving; capacity is growing, and new facilities are developing. Reinsurance also is more available, but prices remain high. One D & O insurer has reentered the market covering small and emerging businesses after not writing any D & O for eighteen months.

The NAIC December, 1986 report on the availability of D & O coverage concluded that the line is experiencing some improvements although coverage is still not available for certain risks, and deductibles and premiums have increased, with desired limits not always available. Underwriters have indicated to

NAIC, however, that they have increased previous limits and are writing new business.

A recent poll of Fortune 1,000 companies conducted by Heidrick & Struggles (an executive search firm) found that D & O insurance premiums increased by an average of 506% in 1986. Twenty percent of the poll's respondents reported that their D & O insurance premium had increased by more than 999% over 1985.

Bank Fidelity Bond Coverage

The American Bankers Association has created a captive to provide D & O coverage of up to \$2 million and bankers blanket bonds of up to \$3 million.

Motor Carrier Liability Coverage

While there still are serious problems (see discussion *infra*), there appear to be improvements in the availability of long-haul trucking coverage -- primarily as a result of less difficulty in obtaining reinsurance.

Liquor Liability Coverage

Coverage for liquor liability is still a severe problem in some areas of the United States. A recently completed NAIC survey of liquor liability coverage concluded that there is an availability problem, but it varies significantly among the States and by type of liquor establishment. Demand for liquor liability coverage has increased as more liquor vendors who previously were uninsured have sought to obtain coverage. As demand has increased, capacity, particularly in excess lines, has diminished.

Medical Malpractice Insurance

Medical malpractice insurance remains exceptionally tight. The major commercial insurers are writing only renewals, and are not writing new policies. Substantial insurance is being written by physician captive mutuals. The formation of two medical malpractice risk retention groups should increase capacity.

Commercial General Liability (CGL)

Commercial General Liability policies are available for most but not all risks. Prices have stabilized at the higher levels,

and no further major increases are predicted for the near future. The new CGL forms exclude pollution liability; while this may increase availability, it necessitates the purchase of pollution liability separately (where available) or self-insurance.

Product liability coverage is still tight for long-tail products, as well as specific products such as pharmaceuticals and chemicals.

Excess Coverage

Excess coverage for large risks continues to be difficult to find, but the availability situation has eased considerably. Brokers reportedly are able to assemble excess liability limits of \$50 million to \$100 million by using conventional markets, and even higher limits through the use of alternative markets. Capacity in excess coverage for liability risks has expanded with the entry of new insurers. Primary among these is X.L. Insurance Co., Ltd., an insurer formed by over sixty major corporations, and American Casualty Excess Insurance, Ltd., a syndicate of large insurers. These companies are reported to have begun offering policies covering claims in excess of \$25 million.

Reinsurance

Capacity is increasing both in the United States and London reinsurance markets. It is estimated that the United States market has twice the capacity for general liability and specialty casualty risks it had a year ago.

Capacity in the London market is up significantly, but a number of restrictive coverage clauses are in use. London reinsurers are providing reinsurance for the United States, but are restricting coverage through the use of sunset clauses, date of loss clauses, event definitions, exposure unit rating, and pollution exclusion clauses. London insurers have expressed a preference for covering homogeneous risks under a treaty, a preference that might make Risk Retention Groups attractive risks.

II. Sectoral Summaries

Trade associations representing each of the sectors discussed in the Working Group's prior Report were contacted for updated information. A few of the contacted associations had no new information. The following is a summary of the available updated information.

Municipalities

Municipalities, with some exceptions, continue to face serious difficulties in obtaining insurance. There has been a substantial movement toward both self-insurance and pooling arrangements among municipalities. For example, in California, 21 municipal liability pools cover 350 of the State's 444 cities. NAIC's Subcommittee on Governmental Liability (chaired by the Alliance of American Insurers) conducted a survey of market conditions over the past eighteen months, and concluded that -- available capacity has dropped significantly. Several insurers and reinsurers have dropped out of the municipal liability market. The remaining insurers are raising prices and tightening underwriting terms, including moving to claims-made forms for some lines.

Transportation

Railroads have experienced a complete unavailability of insurance for requirements in excess of \$20 million in the past year. To solve this problem several railroads joined together to form the Railroad Association of Insurance Limited, a Bermuda captive, specializing in railroad insurance at the \$50 to \$100 million range only. The industry is looking for a similar solution for their \$25 to \$50 million insurance requirements.

According to the General Accounting Office, about 1,300 motor carriers went out of business in 1985 due to lack of insurance. More than 12,000 trucking insurance policies reportedly were cancelled. Carriers have been forced to pay higher premiums for less coverage. The American Trucking Association is working to develop an insurance source for its members. In some States long-haul truck risks have been covered through assigned risk pools.

Publishing

The United States book publishing industry is troubled by both sharply rising costs and unavailability of liability insurance. Policy increases in 1986 averaged 200% to 300% over 1985 premiums, and some publishers have had their deductibles raised from \$25,000 to \$100,000. Reportedly, some policies now pay only for liability judgments but not the cost of defending lawsuits. Publishers of "controversial" books are having difficulty getting liability insurance of any type.

Magazine and newspaper publishers continue to have cost and availability problems, particularly for libel insurance. Premiums for newspapers have risen 10% to 20% over the past year;

those for magazines are up 30% to 200%. This is somewhat less than the doubling and tripling of premiums experienced by both newspaper and magazine publishers in 1985. Deductibles continue to rise, but more modestly than in 1985, when they more than doubled for many companies.

Nurse-Midwives

In July, 1986 ten insurers formed a consortium to provide professional liability insurance for certified nurse-midwives who are members of the American College of Nurse-Midwives. Policies are written on a claims-made basis and offer three different limits of coverage. This action followed the release of a study funded by the insurance industry which identified risk characteristics and risk management techniques, and which also presented proposed liability rates. These actions are believed to have alleviated availability problems in this line.

Dairy and Food Industries

A February, 1986 survey of its members by the Drug and Food Industries Supply Association generated responses from 21% of its membership. Ninety-five percent of the respondents found liability insurance coverage to be available, and 93% of these had experienced premium increases for the same or less coverage. Thirty-four percent had increases of 10% to 50%; 22% had increases between 51% and 100%; 35% reported increases between 101% to 500%, and 3% had increases over 500%. Respondents reported difficulty in obtaining satisfactory coverage in:

Products	55% of respondents	
General (Casualty)	32%	"
Officer and Director	15%	"
Umbrella or Excess	15%	"
Transportation	12%	"
Environmental	11%	"
Professional	6%	"

Architects and Engineers

A survey of 1,600 firms conducted by the American Consulting Engineers Council found that engineers nationwide experienced average increases of 43% in the cost of their professional liability insurance in 1986 over 1985. Structural engineering and small firms were hit the hardest. Nineteen percent of the survey respondents reported "going bare" in 1986, compared with 13% in 1985.

Day Care Centers

Problems continue with both availability and affordability for some day care centers, although the situation seems to have eased somewhat since 1985. Problems appear to be greatest for home day care providers caring for more than three children and for small commercial operations. As of May, 1986, CAL-CARE, the California market assistance plan for day care centers, had received 320 completed applications -- of those, 238 applicants received quotes, 43 were rejected for not meeting underwriting standards, and 39 were pending.

Toy Manufacturers

The Toy Manufacturers of America reports that established members of the industry are having no problems obtaining liability insurance, but that some small companies just entering the market have been unable to obtain insurance. During 1986, of the 99 companies that contacted the association about their premiums, 50% had increases of 25% or more, 30% had increases of 15% to 24%, and the remainder had no change in their premiums.

Thirty-five to forty small companies are considering the development of a captive insurance plan for the industry.

Household Appliance Manufacturers

The problem of insurance costs remains as serious as a year ago. Costs are reported to be still increasing. Companies are generally able to get primary coverage of one million dollars, but they have difficulty getting coverage above that amount. The Association of Home Appliance Manufacturers is considering setting up a captive insurer if reinsurance can be obtained.

Medical Equipment

Although product liability insurance remains an urgent problem for the medical equipment industry, the situation has improved slightly over 1985 and early 1986, when one in five members of the Health Industry Manufacturers Association had its insurance cancelled or not renewed. Insurance availability is expected to improve in 1987, so that the majority of companies will be able to obtain insurance, with rates expected to remain at current levels. But members more often are getting claims-made policies with legal defense costs included in the overall settlement limits. The Medical Device Mutual Assurance and Reinsurance Company, a captive, has seen its membership increase between September 1984 and September 1986 from 35 to 305.

companies. As of December, 1986, membership stood at 325 companies.

Chemical and Pharmaceutical

Availability and adequacy of insurance continue to be problems for these companies. Sudden and accidental pollution coverage reportedly is almost non-existent in the chemical industry. Premiums are increasing 200% to 500%, with some increases as high as 1,000%.

Biotechnology

The two major trade associations, the Association of Biotechnology Companies (ABC) and the Industrial Biotechnology Association (IBA), report that availability and affordability of liability insurance remains problematic, particularly for small companies. ABC, which represents many small new firms, has set up a captive cooperative insurance company in Vermont to provide product liability and D & O liability coverage. IBA, which represents larger companies, decided against setting up a captive since its members have been able to get insurance. The associations report that no companies have curtailed operations because of insurance problems, but that some small companies are "going bare." The biotechnology sector's insurance difficulties are compounded by the presence of new small companies with high risk profiles, as well as research and development operations in high risk areas of pharmaceuticals, biologicals, chemicals and environmental applications.

Oil and Gas Drilling

A survey conducted in May, 1986 by the International Association of Drilling Contractors found that the average premium more than tripled over the last two years, and that some premiums are almost twenty times higher than two years ago.

Construction Contractors

A 1986 survey of 500 construction contractors found that "skyrocketing insurance premiums" is the most serious problem facing the construction industry. The average liability insurance premium for construction contractors increased by 50% in 1985, and nearly doubled for architect/engineering firms. Availability has been especially difficult for new companies and companies involved in tunnelling, hazardous waste clean-up and crane operations.

In April, 1986 a \$125 million water tunnel project for New York City was stopped for a month because a contractor's liability insurance policy had expired. The group of carriers which insures this type of work has discontinued insuring tunnel projects. There is an increasing tendency for small construction companies to continue working without liability insurance.

Tank Truck Carriers

Tank truck carriers are required by the Department of Transportation to have either \$1 million or \$5 million coverage for public liability, property damage and environmental restoration, depending on the type of hazardous material being transported. The National Tank Truck Carriers (NTTC) reported that the cost of renewed coverage after June, 1985, jumped 500% to 700% over the previous twelve-month period, with coverage over \$5 million very difficult to obtain. An NTTC survey also found that many of those renewing after January 1, 1985 faced increased deductible amounts of over \$21,000 per occurrence. Some carriers are not renewing policies. One New England company reported that its insurance premium is 21% of its gross annual revenue. Several companies have gone into bankruptcy, and two have gone out of business entirely.

Service Station Dealers

According to the Service Station Dealers Association, its members are finding it difficult to find pollution liability insurance. Last year only 3.5% of these dealers had pollution insurance, and most of those that did had limitations which negated much of the coverage. Two firms have found it necessary to waive requirements that their dealers maintain specific coverage until coverage becomes more affordable.

General Manufacturing

The Machinery and Allied Products Institute recently updated its survey of liability coverages of member companies. The survey was completed by companies which experienced policy renewals after April 1, 1986. The survey covered general liability, D & O liability, environmental impairment liability, products liability and some other coverages.

Respondents experienced premium increases for all types of insurance, but the increases, except for products, were less than reported for 1985. Limits tended to be the same as previously for all coverages, with the exception of Excess General Liability -- where a majority of the respondents found less market capacity. Increases in deductibles were most noticeable in D & O

coverage, where 68% of the respondents experienced increases, and in products coverages, where 73% experienced increases.

An overwhelming majority reported an increase in exclusions. Fifty-eight percent indicated that their general liability coverage now excludes "sudden and accidental" pollution of the environment. Exclusions from D & O coverage included liability resulting from mergers and acquisitions, suits brought against a director by the corporation or other directors, suits against named directors, and suits for failure to maintain adequate insurance coverage.

Seventy percent reported that they have been compelled to shift to a "claims-made" form, and approximately 27% have had some coverage cancelled since April 1, 1986. More than half of the respondents indicated that they are either sponsors or shareholders of American Casualty Excess Insurance, Ltd., or X.L. Insurance Co., Ltd., or that they are considering these options. Other respondents are considering association captives.

Machine Tool Manufacturers

The 1986 product liability survey of the National Machine Tool Builders Association indicates that 23% of its members have no product liability coverage. For those who do have such coverage, premiums have risen by 55% over the last year, and have more than tripled since early 1985. The Association reports that 43% of its members with annual sales in excess of \$2.5 million have no umbrella policy against catastrophic claims.

Steel Industry

The steel industry continues to have problems with the availability and affordability of liability insurance. Premiums remain high, and available coverage generally includes large deductibles.

General Aviation Manufacturers

General aviation continues to have serious insurance affordability problems. The General Aviation Manufacturers Association estimates that the average cost of product liability coverage in 1986 will approach \$100,000 per airplane delivered compared to \$70,000 per airplane in 1985, with fewer delivered airplanes in 1986.

Cessna's product liability insurance costs increased from \$7.3 million in 1983 to \$50 million in 1986. Piper's costs increased from \$7 million in 1983 to \$40 million in 1985. Beech

experienced product liability insurance costs of \$24 million in 1986.

Commercial Airlines

The Air Transport Association reports that there is sufficient capacity in the market for its members to buy what they need. Premiums in 1985 were 40% greater than in 1984.

Ice Skating Rinks

Fifty percent of ice skating rinks report they cannot obtain liability coverage and may be forced to close.

Sports Leagues

The Amateur Softball Association, composed of 182,000 teams with 3.5 million participants in 1985, had a premium increase of over 2,000%, from \$7,000 in 1985 to \$150,000 in 1986.

The Soccer Association for Youth Organization, which oversees 4,600 youth soccer teams, experienced an increase in its liability insurance cost from \$4,500 in 1984 to \$22,000 in 1985 for the same coverage.

Sports Equipment

A producer of baseball and softball equipment saw its premiums rise from \$14,300 in 1984-85 for \$500,000 worth of coverage to \$70,000 for the same coverage in 1985-86. For 1986-87, it was quoted a premium of \$159,000, the lowest from among only five companies that were willing to bid.

Premium increases of 200% to 500% have forced 20% of small diving equipment producers to "go bare" or self-insure.

III. The Impact of Insurance Availability/Affordability Problems

The above sectoral and industry descriptions, though informative, do not fully tell the story of the insurance availability and affordability problems that still beset many businesses, professionals, employees and consumers. The following items, while admittedly anecdotal, perhaps give a better sense of the real and continuing costs associated with unavailable or unaffordable insurance.

- o Several domestic sports equipment manufacturers have ceased doing business, discontinued some products, and failed to introduce other products, as a result of liability insurance problems. The Sporting Goods Manufacturers Association reports that the number of manufacturers of varsity football helmets has dropped from eighteen in 1976 to three in 1985. There are no longer any domestic producers of trampolines or ice hockey protective equipment. A lacrosse equipment manufacturer was unable to introduce a new helmet on the market because the plastic manufacturer was concerned about product liability. Spaulding Sports Worldwide indicates that it no longer manufactures and sells protective equipment because of increased insurance costs and increases in the number of associated product liability suits.
- o A Massachusetts company has refused to place its metal folding crib on the market because of its inability to obtain liability insurance. The product has been certified as meeting government safety standards, and a substantial number of orders for the product have been received.
- o In a letter to a Congressional subcommittee, the Merchants Corporation of America stated that it had been prepared to begin production of a new infant car seat which it believed would be the highest quality unit available, but that it ultimately decided not to market the product because of the liability risks to which the company would be exposed.
- o A Charlottesville, Virginia health products company refused to market a new product for use in dialysis until it eventually obtained insurance.
- o A small Virginia business manufacturing driving aids for the handicapped removed its product from the market following a dramatic increase in its cost of insurance.
- o Puritan-Bennett, a manufacturer of hospital equipment, stopped making anesthesia gas machines because of its inability to obtain insurance. Puritan-Bennett was the sole domestic manufacturer of such machines.
- o The Dyneet Corporation has stopped producing its clutch for helicopters because the cost of insurance has become prohibitive. No damages claims for the product have been reported.
- o General aviation manufacturers have stopped or suspended production of a number of product lines. For

example, in early 1986, Piper Aircraft suspended production of general aviation aircraft models, and has now resumed production of only one of these models. Similarly, Beech Aircraft suspended production in 1985, with only one model in production at this time, while Cessna suspended production of all of its piston powered aircraft in May of 1986, and has yet to resume production. Each of these manufacturers indicates that product liability costs have been an important factor in these decisions, in that the cost of insurance now often exceeds all other costs of manufacture. Employee layoffs accompanied these product removals.

- o In January, 1986, G. D. Searle and Company announced it would withdraw its Copper 7 IUD from the U.S. market, citing the unavailability of insurance and the threat of product liability lawsuits as the reason for its decision. Searle's withdrawal leaves only a single manufacturer of IUD's in the United States market.
- o A recent editorial in the Journal of the American Medical Association states that because of liability concerns 12% of obstetricians nationwide have stopped delivering babies and 38% of surgeons are avoiding high-risk cases, and that the National Cancer Institute believes that liability fears have led physicians treating cancer to use far milder doses of chemotherapy.⁴

These are but a few examples of products or services that have been removed from the marketplace because of insurance availability/affordability problems. Ironically, many of these products or services would have promoted public health and safety.

IV. The Adequacy of Insurance Coverage

The foregoing discussion has focused almost entirely on the availability and affordability of insurance. But as the Working Group's prior Report noted, there is a third important facet to the insurance crisis -- the adequacy of insurance coverage.

While insurance is more available than a year ago, it is important to note that much of this new availability has come with far higher deductibles, more exclusions, less coverage and additional policy limitations. Accordingly, the higher premiums discussed in this Chapter reflect only a portion of the increased

⁴ "Beyond Tort Reform," 257 JAMA 827 (1987).

cost of insurance. To the extent that these premium increases are accompanied by higher deductibles, less coverage and new exclusions and limitations, the cost of insurance to its purchasers has increased beyond merely the growth in premiums. In other words, not only have insurance premiums increased, but the coverage that can be purchased with those premiums usually is less -- often substantially less -- than what it was a year or two ago.

While the growth in insurance premiums can be measured relatively easily, it is virtually impossible to express the reductions in insurance coverage in similar numerical terms. There thus is a tendency to focus on insurance premiums, and to ignore changes in coverage. But the latter can be just as important -- and can have an even larger effect on the ultimate cost of insurance -- than raw premium data.

Accordingly, this Chapter's discussion of insurance availability and affordability provides only a partial picture of the state of insurance in the United States in that it does not account for the reductions in insurance coverage which have helped both to increase the availability of insurance and to stabilize insurance premiums.

* * *

In sum, while the crisis in insurance availability and affordability has ameliorated as a result of the improved economic conditions of the insurance industry, the insurance problems of the past two years have by no means disappeared. Prices have largely stabilized, but remain very high, and for some lines continue to increase. The availability problems which one year ago affected almost every sector of the American economy are now limited to specific lines or types of coverage. But for those lines or types of coverage the problem is still serious and often a matter of economic survival. Many of the newer developments, particularly the increasing use of self-insurance programs, have yet to prove their long-term reliability. And insurance coverage has been substantially reduced through higher deductibles, lower coverage limits and additional policy exclusions and limitations. Thus, while the shock and many of the more extreme aspects of the insurance crisis have abated, the simple reality is that its effects are still felt throughout the American economy and likely will continue to be felt for some time to come.

CHAPTER 2

THE INSURANCE INDUSTRY'S ECONOMIC PERFORMANCE

In its Report last year, the Working Group discussed relevant data on the financial state of the property/casualty insurance industry. The following updates that discussion with available 1986 data.

I. The Industry's Operating Performance

In its February, 1986 Report, the Working Group noted that there were conflicting views of the economic performance of the property/casualty insurance industry in 1985. While overall premiums were up substantially, some of the problem lines were returning very high losses for their proportion of generated premiums. Consequently, the industry in 1985 had only a small operating profit after tax rebates.

In its year-end review of the 1986 performance of the industry, appropriately entitled "Up From the Ashes," A. M. Best Insurance Management Reports estimated the 1986 operating profit of the property/casualty industry to be \$4.5 billion, with an expected \$1.5 billion in tax rebates, for a total operating profit of \$6 billion.

The property/casualty industry had a statutory insurance underwriting loss in 1986 of \$17 billion on net written premiums of \$176.4 billion. The loss figure is the total of estimated claims losses (payouts), loss adjustment expenses, operating expenses and policyholder dividends. The comparable underwriting loss for 1985 was \$25.2 billion on \$143.9 net written premiums. The corresponding 1984 figures were \$117.7 billion in premiums with a \$21.5 billion net underwriting loss.

The table below summarizes premium and cost data for the years 1981 to 1986.

Property/Casualty Operating Results

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Under- writing Expenses (Billions)	Statutory Under- writing Loss After Policyholder Dividends (Billions)
1981	\$ 98.8	\$ 75.8	\$ 27.1	\$ - 6.3
1982	103.1	82.2	29.0	-10.4
1983	107.8	87.7	30.8	-13.3
1984	117.7	103.7	33.0	-21.5
1985	143.9	126.8	37.4	-25.2
1986*	176.4	145.5	43.7	-17.0

*Estimated

Source: Best's Insurance
Management Reports

The substantial growth in net written premiums from 1984 to 1986 -- a 50% increase -- and the reduction in the loss and loss adjustment expense ratio -- from 88.09% to 82.49% -- have been major factors in restoring the industry's financial health. The industry also was able to generate substantial income through its investments, which gave it an overall net operating profit. Specifically, the industry's 1986 \$21.6 billion investment gain offset the \$17 billion underwriting loss for a net \$4.5 billion profit. Further, tax recovery of \$1.5 billion raised the total operating profit to \$6 billion. Additionally, the industry realized capital gains of \$5.5 billion, resulting in a final estimated after-tax profit of \$11.5 billion.

The \$11.5 billion in after-tax profits of the property/casualty industry significantly improved the industry's rate of return on net worth. Its rate of return for 1984 was 1.8%, and increased to 3.8% in 1985.⁵ The industry's rate of return on net worth for 1986 was 11.6%.⁶ This rate of return is roughly

⁵ Insurance Information Institute, 1986-87 Property/Casualty Fact Book 22. These figures are based on Generally Accepted Accounting Principles ("GAAP"). The comparable statutory accounting rates of return were 1.7% and 2.8%.

⁶ This is the statutory accounting rate of return. GAAP figures for 1986 are not yet available. From 1976 to 1985, the
(continued...)

equivalent to the industry's ten-year average for 1976 to 1985 (11.9% statutory accounting; 11% GAAP accounting), and is slightly less than the ten-year rate of return for Fortune 500 industrial corporations (13.2%).⁷ Thus, while the industry significantly improved its rate of return, that rate was substantially less than its most recent high years (19% in 1977 and 18.1% in 1978⁸), and was still less than the rate of return of many companies competing with the industry for investment capital (see Chart A).

One measure of the industry's performance is a ratio that measures all costs against premiums written and earned. This ratio -- the combined ratio -- dropped from the 1985 level of 114.8% to 107% in 1986. The ratio's recent peak was 116.1% in 1984. If premiums continue for another year at the current level, and natural catastrophic losses remain as low as they were in 1986, a further drop in the combined ratio can be expected.

The lower combined ratio for the industry can be partly attributed to the reduction in the ratios of the problem lines, though these lines continue to be a substantial drain on the industry's financial performance. Medical Malpractice still has a combined ratio of 144.4%, but is down from 166.7% in 1985. Commercial Multiple Peril and Other Liability are the two lines which include products, municipal, D & O, general liability and other problem coverages. The combined ratio for Commercial Multiple Peril dropped from 122% in 1985 to a respectable 97.2% in 1986, with the combined ratio for Other Liability dropping from 147.2% in 1985 to a still high 120.3% in 1986. Further reductions in these ratios should add materially to the industry's stability.

Another important measure of the industry's performance is the change in policyholder surplus. That surplus generally is equated to net worth, and is a measure of the industry's ability to withstand future losses. The table below provides the detailed calculation of policyholder surplus, which is estimated to have reached \$91 billion at the end of 1986, a 21.5% increase over 1985.

⁶(...continued)

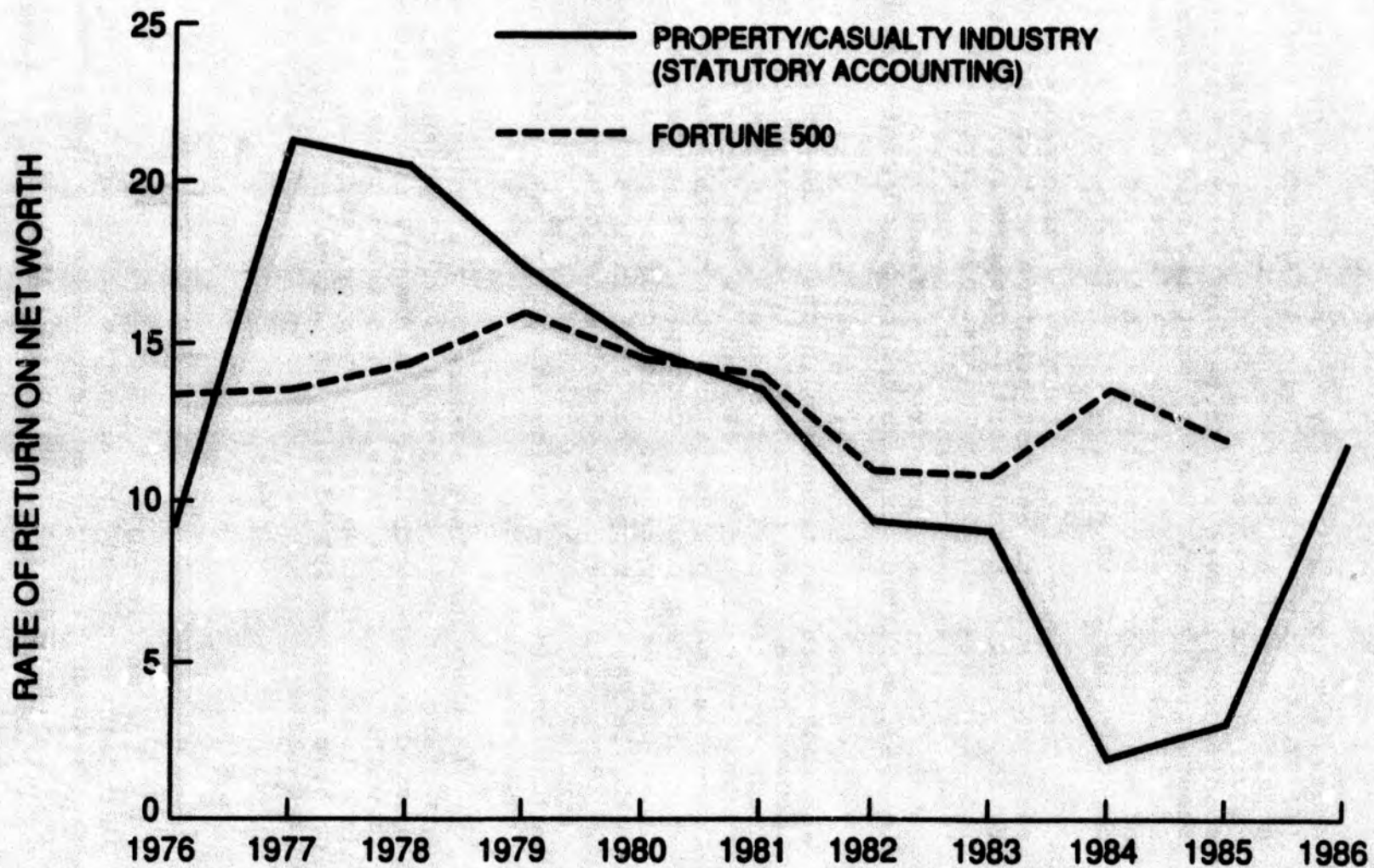
GAAP figures closely tracked the statutory accounting figures, and in seven of those ten years showed a lower rate of return.

⁷ 1986-87 Property/Casualty Fact Book, at page 22.

⁸ The statutory accounting rates of return for 1977 and 1978 were 21.3% and 20.5% respectively. Id.

CHART A

**ANNUAL RATE OF RETURN AS A
PERCENT OF NET WORTH**



SOURCE: INSURANCE INFORMATION INSTITUTE (BASED ON DATA COMPILED BY A.M. BEST AND FORTUNE MAGAZINE)

**1986 ESTIMATED CHANGES
IN CONSOLIDATED POLICYHOLDERS' SURPLUS**

	(\$ millions)
Policyholders' Surplus Jan. 1, 1986	74,878
Underwriting Loss (After Dividends to Policyholders)	-17,000
Net Investment Income	21,600
Other Income	- 100
Operating Earnings before Federal Income Taxes	4,500
Federal Income Tax Recovery	1,500
Operating Earnings After Federal Income Taxes	6,000
Realized Capital Gains (After Tax)	5,500
Unrealized Capital Gains	4,500
Capital & Surplus Paid In	4,000
Dividends to Stockholders	- 2,700
All Other Surplus Changes	- 1,178
Total All Changes	16,122
Policyholders' Surplus Dec. 31, 1986	91,000

Source: Best's Insurance
Management Report

II. Underwriting Results by Major Lines

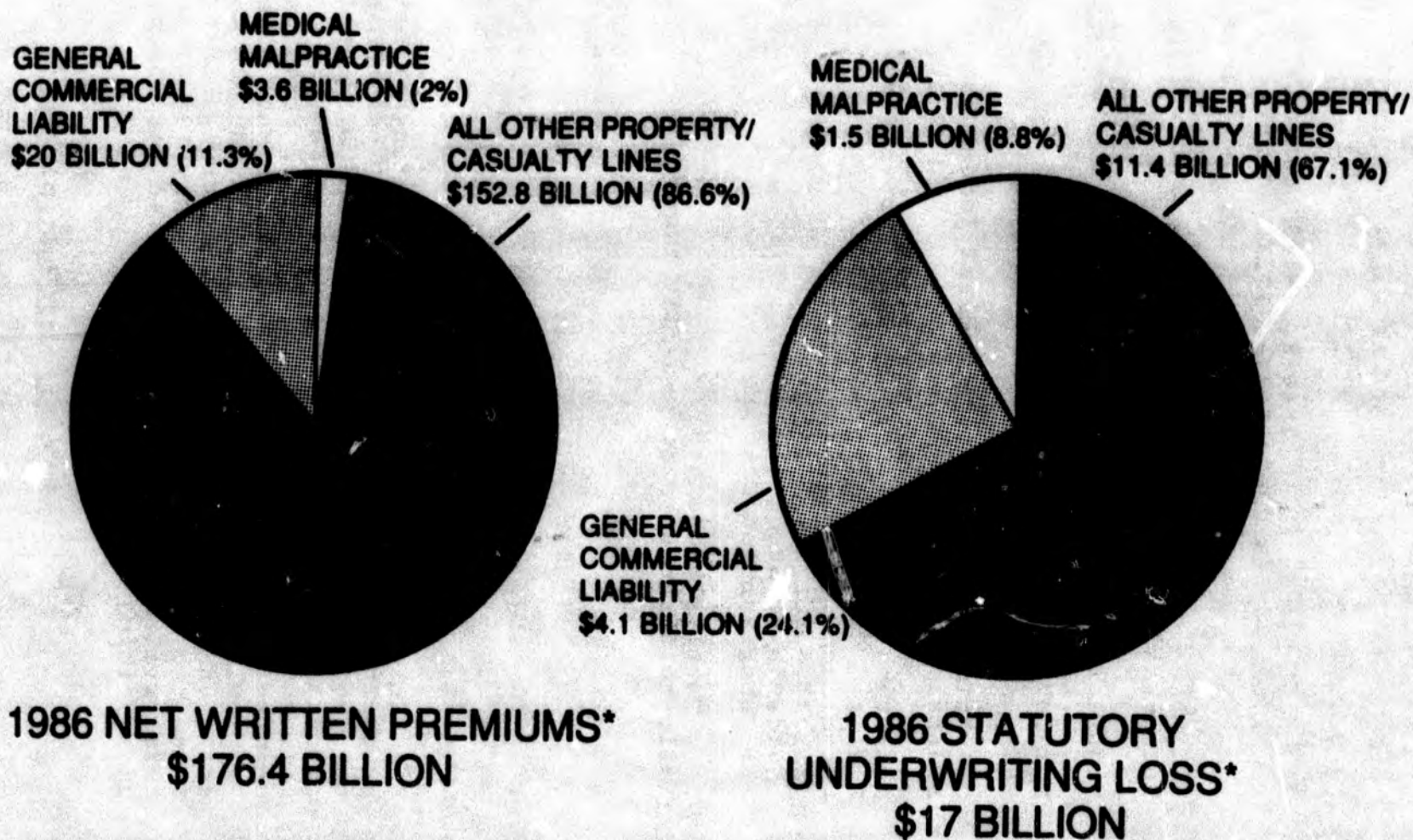
In order to understand the relationship between the property/casualty industry's financial performance and the problems in insurance availability and affordability, it is important to examine the underwriting results of the major commercial liability lines: Commercial Multiple Peril (CMP), Commercial General Liability (CGL) and Medical Malpractice. Particularly the latter two lines continue to be a substantial drain on the property/casualty industry's financial performance. These two lines together produced only 13% of the industry's total written premiums, but accounted for 33% of its total underwriting loss (see Chart B).

Commercial Multiple Peril

CMP is a packaged line including general liability coverages such as product liability. The general liability lines are subject to long-tail losses which may be reported many years

CHART B

WRITTEN PREMIUMS COMPARED TO UNDERWRITING LOSS



SOURCE: BEST'S INSURANCE MANAGEMENT REPORTS

*ESTIMATED

after the policy is written and often involve claims which are not resolved until long after having been reported. The line also includes property coverage that is typically reported and resolved in a short time frame.

CMP experience for the past six years is summarized below.

Commercial Multiple Peril

	Net Premiums Written	Loss and LAE	Under- writing Expenses	Statutory Under- writing Loss After Policyholder Dividends
Year	(Billions)	(Billions)	(Billions)	(Billions)
1981	\$ 6.8	\$ 4.6	\$ 2.5	\$ -0.5
1982	6.9	5.3	2.7	-1.2
1983	7.2	5.9	2.9	-1.7
1984	8.2	7.9	3.2	-2.9
1985	12.0	9.0	4.0	-2.8
1986*	16.0	9.4	5.0	-0.1

*Estimated

Source: Best's Insurance
Management Reports

Best's Management Reports predicted in 1985 that the short-tail portion of this coverage could provide a fast turnaround in the CMP line. The combination of a nearly 40% increase in net written premiums and the drop in natural disaster costs in 1986 apparently has led to the sharp improvement in the line.

Commercial General Liability

This line includes most of the sectors which have experienced serious affordability and availability problems. It is also a long-tail line. The line's experience for the past six years is summarized below.

Commercial General Liability

	Net Premiums Written	Loss and LAE	Under- writing Expenses	Statutory Under- writing Loss After Policyholder Dividends
Year	(Billions)	(Billions)	(Billions)	(Billions)
1981	\$ 6.0	\$ 5.1	\$ 1.8	\$ -1.0
1982	5.6	5.4	1.8	-1.7
1983	5.7	6.0	1.8	-2.1
1984	6.5	7.8	1.9	-3.2
1985	11.6	11.5	2.7	-4.9
1986*	20.0	16.4	4.2	-4.1

*Estimated

Source: Best's Insurance
Management Reports

Premiums in this line increased more than 20% in the past year after a similar increase from 1984 to 1985. But losses increased 43% during 1986, while underwriting expenses increased 52%. Accordingly, net underwriting losses in the line remain extremely high.⁹

⁹ The statutory underwriting loss is based on earned premiums rather than written premiums. Earned premiums in 1985 and 1986 were substantially less than written premiums. The following table summarizes the net earned premiums over the last six years for the property/casualty industry and the three analyzed lines.

Net Premiums Earned

	Property/Casualty Industry	CMP	CGL	Medical Malpractice
Year	(Billions)	(Billions)	(Billions)	(Billions)
1981	\$ 97.0	\$ 6.7	\$ 6.1	\$ 1.3
1982	101.0	6.8	5.7	1.4
1983	105.8	7.1	5.7	1.5
1984	114.3	7.8	6.2	1.7
1985	132.7	10.2	9.4	2.4
1986*	164.7	14.3	16.6	3.3

*Estimated

Source: Best's Insurance
Management Reports

Medical Malpractice

Medical malpractice remains a major source of losses and continues to be a substantial problem for the medical profession and consumers. Only a few private insurers provide coverage, with State mutuals and self-insurance taking up much of the slack. The following summarizes the line's experience over the past six years.

Medical Malpractice

	Net Premiums Written	Loss and LAE	Under- writing Expenses	Statutory Under- writing Loss After Policyholder Dividends
Year	(Billions)	(Billions)	(Billions)	(Billions)
1981	\$ 1.3	\$ 1.6	\$ 0.2	\$ -0.5
1982	1.5	2.0	0.2	-0.7
1983	1.6	2.1	0.2	-0.8
1984	1.8	2.8	0.3	-1.1
1985	2.8	3.7	0.4	-1.7
1986*	3.6	4.3	0.4	-1.5

*Estimated

Source: Best's Insurance
Management Reports

Although the experience indicates a slight improvement in underwriting losses in 1986, the line continues to have the highest combined ratio of the problem lines.

III. Stock Market Performance

During the past four to six months some pessimistic reports from insurance stock analysts have contributed to a decline in many property/casualty and multi-line insurance company stocks. Many analysts continue to recommend insurance stocks, but caution that investors should be very "selective."

Most analysts, however, believe that the industry "learned a lesson" from the excesses of the early 1980's and that prices, which are stabilizing, will be maintained through 1987 and into 1988. They see interest rates remaining at current levels, and expect insurance profits to be healthy for the immediate future. They believe that the property/casualty and multi-line companies will have low price to earnings ratios and, therefore, be attractive to investors.

While property/casualty stocks generally outperformed the market from January 1, 1984 to January 1, 1986, for the first three quarters of 1986 property/casualty stocks actually trailed the market's performance. A recent issue of Business Insurance¹⁰ reported that property/casualty stocks seriously lagged behind the Standard and Poor's 500 and the Dow Jones Industrials during the second half of 1986.

The Value Line, a comprehensive stock analysis firm, reports regularly on fourteen property/casualty stocks. Its October, 1986 report noted that these stocks have not performed well during the past six months. It believes that the insurance industry must build its reserves, and that to do so the industry will remain conservative in its underwriting. Accordingly, Value Line concludes that the market will remain tight for at least the near future. In commenting on the new tax law, Value Line predicts that the industry will be able to pass on the resulting increased costs, but that the provisions may require the industry to focus on obtaining underwriting profits, and not to continue to rely -- as it has in the recent past -- on its investment income to achieve overall profitability.

IV. Insolvencies

Accompanying the serious problems that have affected the property/casualty insurance industry over the past few years has been a modest increase in the number of financially troubled companies or insolvencies. This conclusion is based primarily on a review of both Best's ratings and reports of the insurer committee tracking insolvencies and their claims on insurance guaranty funds.

For 1986, Best's evaluated the financial condition of 1,703 property/casualty companies. As a result of this evaluation, 176 companies received higher ratings and 220 had their ratings lowered. In 1986, 124 companies were in the "Other Not Assigned" category, compared to 118 companies in 1985. This category covers companies below minimum standards, those with incomplete financial information, those not listed by company request, and those under State supervision.

As noted, there has been some increase in the number of insolvencies of property/casualty insurers over the past few years, as well as a change in the type of companies facing

¹⁰ "Insurer Stocks Trail Wall Street Gains," Business Insurance, page 2, February 23, 1987. The article indicates that some investors are skeptical that the industry's recent improvement in earnings will continue.

insolvency. The following table shows the number of property/casualty insolvencies between 1969 and 1986. The listing does not include reinsurers, surplus carriers or offshore captives.

Property/Casualty Insolvencies

<u>Year</u>	<u>Insolvencies</u>
1969	1
1970	4
1971	8
1972	2
1973	2
1974	5
1975	20
1976	6
1977	6
1978	6
1979	3
1980	4
1981	6
1982	9
1983	4
1984	20
1985	21
1986	16 (Est.)

Source: National Committee on
Insurance Guaranty Funds.

During the 1960's and 1970's most of the industry insolvencies involved companies writing high risk automobile insurance. This started to change in 1980-81, with a few insolvent commercial lines writers. In 1984 and 1985, there was an increase in insolvencies among commercial lines companies. Among the insolvencies in those years were both mixed and specialty commercial writers whose coverages included asbestos, long haul trucking, dram shop and medical malpractice.

V. The Industry's Profitability Cycle

Much has been made of the property/casualty industry's profitability cycle. Indeed, the Working Group's February, 1986 Report discussed the effect of that cycle on the availability and affordability of insurance. Some have suggested that the entire availability/affordability crisis can be attributed to that cycle, and that there thus is a certain inevitability to the reoccurrence of such insurance problems.

It is important in understanding the contribution of the cycle to the recent availability and affordability crisis to appreciate how much more severe the insurance crisis of the mid-1980's was than the crisis of the mid-1970's. To give but two examples of the difference between the two periods: the industry's underwriting losses of \$21.5 billion in 1984 and \$25 billion in 1985 were vastly greater than its underwriting loss of \$4.2 billion in 1975 (the previous record); and, the industry's operating losses of \$4 billion in 1984 and \$5.6 billion in 1985 also were far larger than its \$300 million operating loss in 1975 (which is all the more astounding in light of the record investment income generated by the industry in 1984 and 1985).¹¹

The insurance crisis of the mid-1980's thus was far deeper and much more severe than the crisis of the mid-1970's. Accordingly, it is misleading to suggest that such industry crises simply reoccur cyclically, and that no other explanation is needed for the recent problems in insurance availability and affordability. Something was substantially different between the two crises which led the latter to be very different from the former. One difference, as Chapter 3 discusses in detail, is that tort law in those ten years underwent a dramatic transformation, both in terms of doctrinal changes as well as in awarded damages. That transformation appears to have played a major role in making the industry's cyclical downturn in the mid-1980's a far more serious insurance crisis than the United States had ever previously faced. This, unfortunately, has ominous implications for the likely effects of the industry's next cyclical downturn should the deterioration of tort law continue unchecked.

¹¹ The Statistical Information Advisory Committee to the NAIC Legal Liability Insurance (D) Task Force, The Report of the Statistical Information Advisory Committee 2.47 (1986).

CHAPTER 3

THE CONTRIBUTION OF TORT LAW TO THE CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY

In its February, 1986 Report the Working Group discussed the central role of tort law to the crisis in insurance availability and affordability. The Report noted four problem areas in tort law which have contributed substantially to the insurance crisis. These four areas are:

- o the movement toward no-fault liability,
- o the undermining of causation,
- o the explosive growth in damage awards, and
- o excessive transaction costs.

The Report also noted the growth in lawsuits in areas such as medical malpractice, product liability and municipal liability. Finally, in discussing the problems of tort law and how they relate to the availability and affordability of insurance, the Report focused on the instability and uncertainty which currently besets the tort system and which greatly exacerbates the already serious deterioration of that system.

I. Jury Awards

While the Working Group's Report dealt with a number of troubling aspects of tort law, most of the critics of the Report's discussion of tort liability have focused on its conclusions regarding the extraordinary growth in damage awards. Ironically, recently updated data issued by the Rand Corporation's Institute for Civil Justice -- which represent by far the most reliable empirical data to date on civil jury awards -- indicate that the Report, if anything, appears to have understated the magnitude of this particular problem.

A. Average Jury Awards

The recently released analysis of the Institute for Civil Justice¹² summarizes civil jury verdict data over a twenty-five year period in two jurisdictions: Cook County, Illinois and San Francisco, California.¹³ The Institute's data are adjusted for inflation, and expressed in terms of 1984 dollars. The data demonstrate an extraordinary growth in civil jury awards in recent years, particularly in two areas that have been of major concern with regard to insurance availability and affordability -- malpractice¹⁴ and product liability. For example, the data show that the average jury malpractice award in Cook County increased by 2,167% from the early 1960's to the early 1980's, and by 830% in San Francisco during the same period. In inflation-adjusted dollars, the average malpractice jury award in Cook County increased from \$52,000 in 1960-64 to \$1,179,000 in 1980-84, with a corresponding increase in San Francisco of from \$125,000 to \$1,162,000 (see Chart C).¹⁵

Product liability jury awards underwent a similar extraordinary increase. Thus, in Cook County the average product liability jury award increased by 212% from the early 1960's to the early 1980's, while in San Francisco the increase during this period amounted to 1,016%. In inflation-adjusted dollars, the average product liability jury award in Cook County increased from \$265,000 in 1960-64 to \$828,000 in 1980-84, with a

¹² M. Peterson, Civil Juries in the 1980s: Trends in Jury Trials and Verdicts in California and Cook County, Illinois (Institute for Civil Justice, 1987).

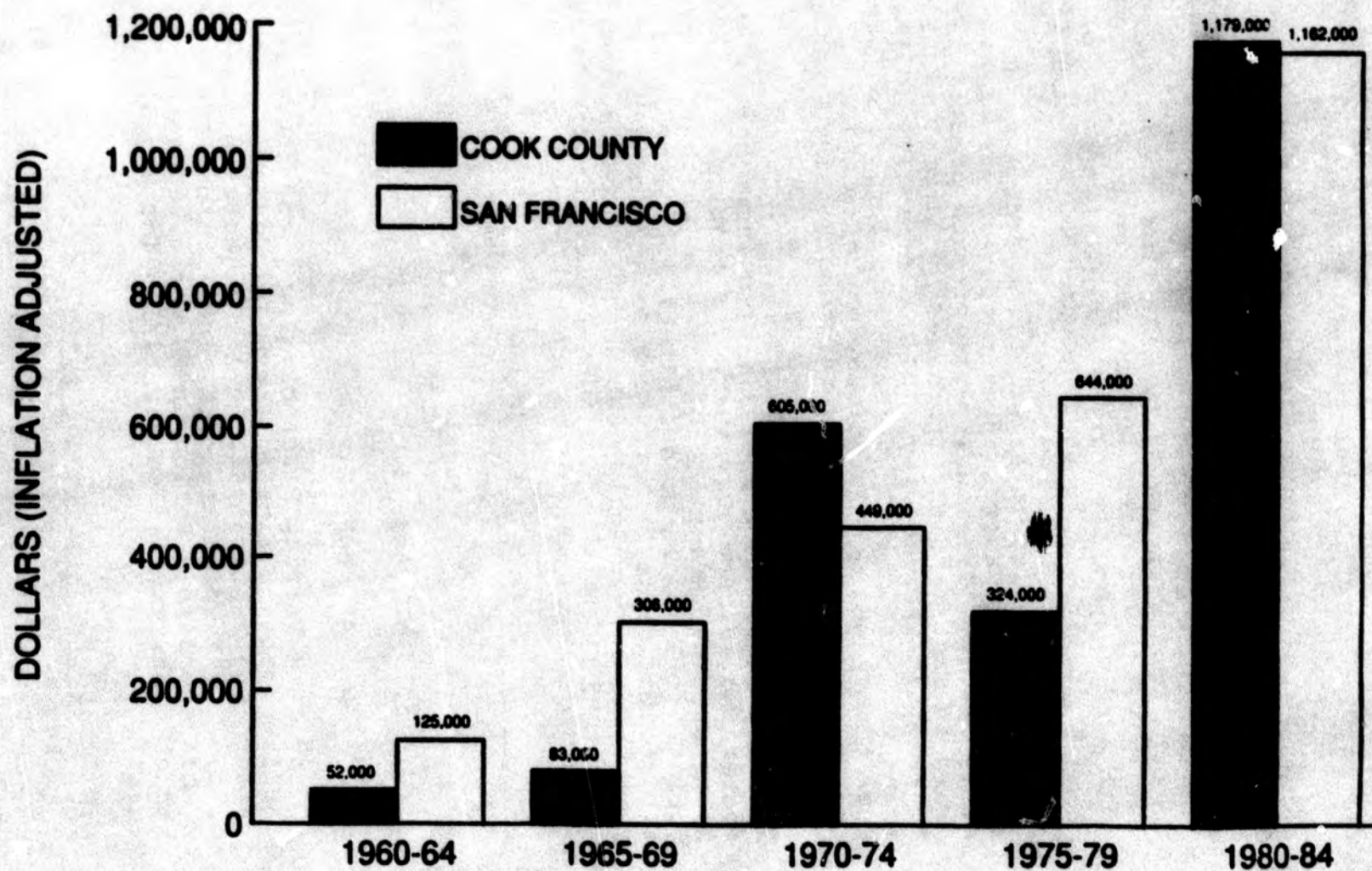
¹³ The Institute for Civil Justice selected Cook County and San Francisco for its jury verdict studies "because they are major urban commercial centers in different regions and because [the Institute] could draw upon jury verdict publications in both to obtain information about long-term trends." *Id.*, at page 1. The jury verdict reporters for each jurisdiction are described by the Institute as "among the best publications of their sort in the country." *Id.*

¹⁴ The malpractice data include not only medical malpractice, but all forms of malpractice liability. While the analysis does not provide separate data on medical malpractice, it is likely that the malpractice data consist predominantly of medical malpractice cases.

¹⁵ Civil Juries in the 1980s, at page 22.

CHART C

AVERAGE MALPRACTICE JURY AWARD



SOURCE: INSTITUTE FOR CIVIL JUSTICE

corresponding increase in San Francisco of from \$99,000 in 1960-64 to \$1,105,000 in 1980-84 (see Chart D).¹⁶

Even when factoring in personal injury lawsuits that typically involve far lower monetary stakes -- such as automobile accident and street hazard cases -- the average jury award has increased substantially over the past two decades. For example, the Institute found that the average personal injury jury award in Cook County increased by 217% from the early 1960's to the early 1980's (from \$59,000 in 1960-64 to \$187,000 in 1980-84), with a corresponding increase in San Francisco of 358% (from \$66,000 in 1960-64 to \$302,000 in 1980-84) (see Chart E).¹⁷

Of particular interest is the fact that the rate of increase of average jury awards appears to have surged dramatically in the early 1980's. Thus, while the average product liability jury award in San Francisco increased by a total of \$209,000 from 1960 to 1979, it increased by \$797,000 from 1979 to 1984.¹⁸ This trend was particularly evident in malpractice jury awards in both Cook County and San Francisco, where roughly half of the entire increase in average jury verdicts since 1960 occurred in the 1980-84 period.

The Institute's analysis also shows that along with increasing average jury awards, plaintiffs also have steadily increased the percentage of cases in which they prevail before juries.¹⁹ Thus, in product liability cases in Cook County and in malpractice cases in both Cook County and San Francisco, plaintiffs have roughly doubled the percentage of tried cases in which they prevail before juries (from approximately one-quarter of such cases in 1960-64 to one-half in 1980-84).²⁰

¹⁶ Id.

¹⁷ Id., at page 35.

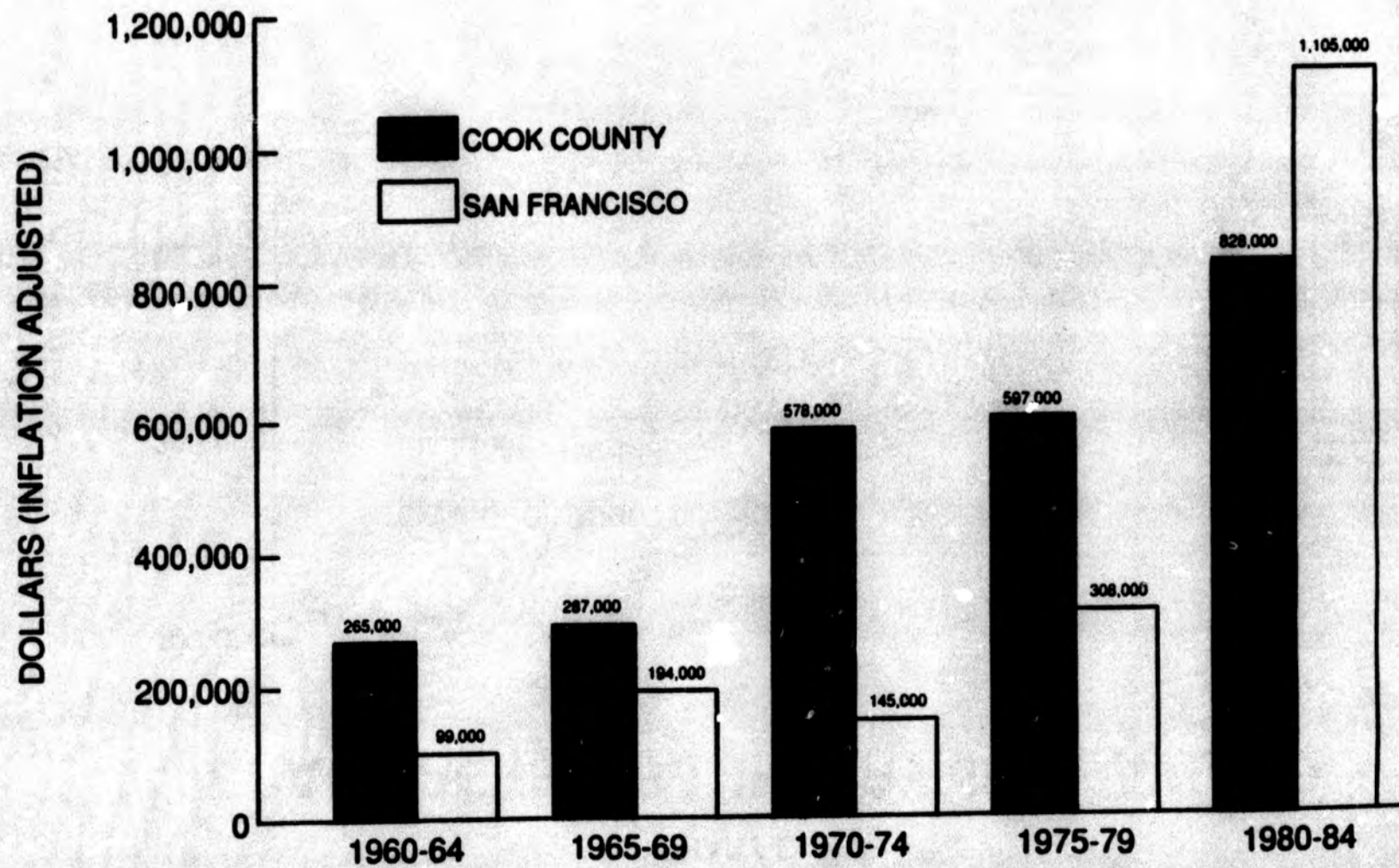
¹⁸ Id., at page 22.

¹⁹ Jury Verdict Research, Inc., corroborates that in product liability cases plaintiffs have increasingly fared better before juries. See Testimony of Philip J. Hermann (Chairman of the Board, Jury Verdict Research, Inc.) before the House Subcommittee on Economic Stabilization on August 6, 1986 ("recovery rate for product liability has substantially increased in the past eight years").

²⁰ Civil Juries in the 1980s, at page 17. Product liability cases in San Francisco are an exception. Plaintiffs' rate of success there has remained roughly constant since 1960, at about one-half of all jury verdicts.

CHART D

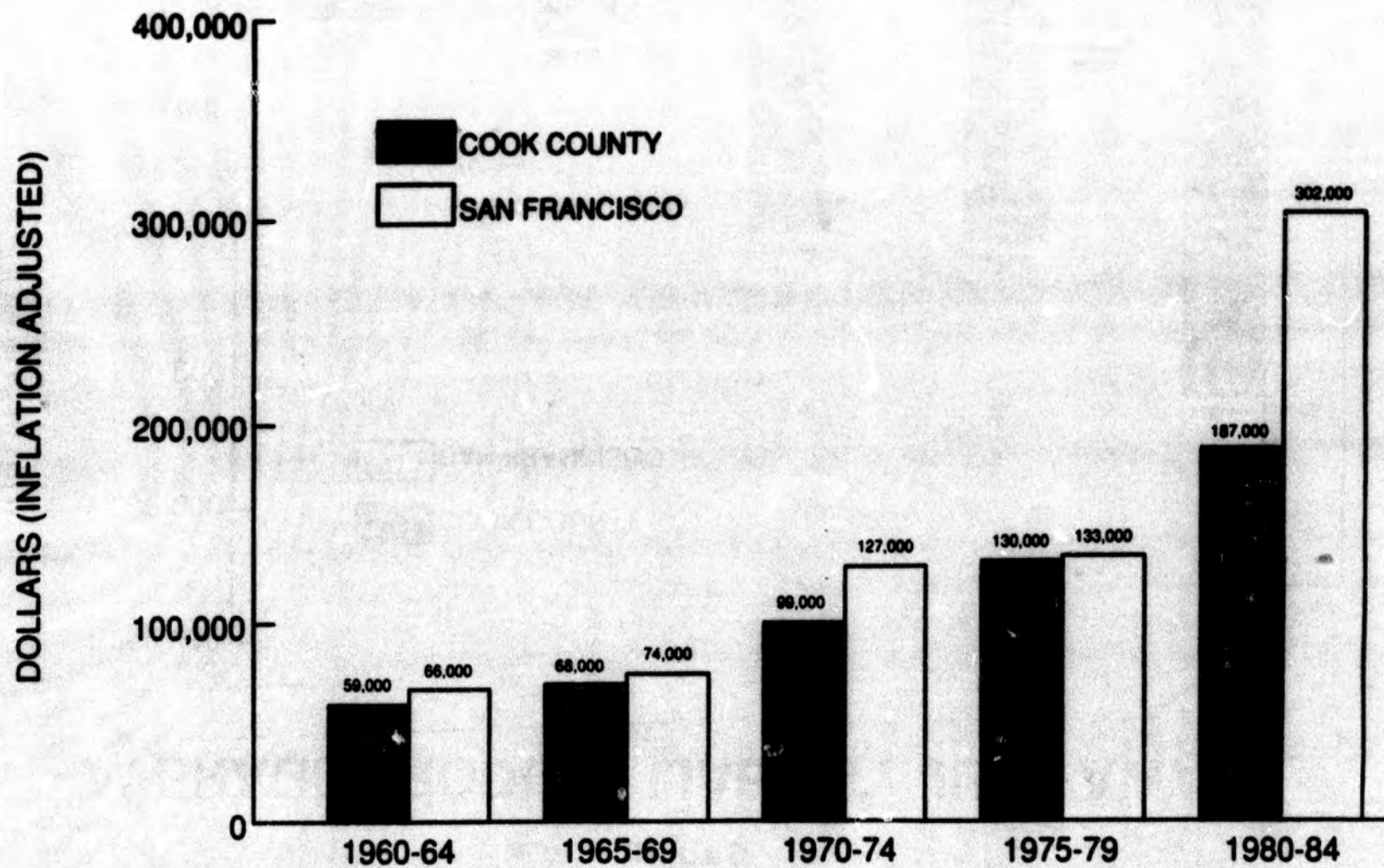
AVERAGE PRODUCT LIABILITY JURY AWARD



SOURCE: INSTITUTE FOR CIVIL JUSTICE

CHART E

AVERAGE PERSONAL INJURY JURY AWARD



SOURCE: INSTITUTE FOR CIVIL JUSTICE

B. Expected Jury Awards

This offers another way of illustrating the change in jury verdicts over the past two decades -- the "expected award"; that is, the average jury award multiplied by plaintiff's likelihood of success.²¹ The expected award for malpractice jury verdicts increased from the early 1960's to the early 1980's by 4,254% in Cook County (from \$13,000 to \$566,000) and by 1,712% in San Francisco (from \$34,000 to \$616,000) (see Chart F).²² During the same period, the expected award for product liability jury verdicts increased by 445% in Cook County (from \$76,000 to \$414,000) and by 927% (from \$56,000 to \$575,000) in San Francisco (see Chart G).²³ Similarly, from the early 1960's to the early 1980's, the expected award for personal injury jury verdicts increased by 307% in Cook County (from \$28,000 to \$114,000) and by 448% in San Francisco (from \$33,000 to \$181,000) (see Chart H).²⁴

The expected award data illustrate even more clearly that the vast bulk of the increase in jury verdicts occurred during the early 1980's. In many of the above categories of cases the increase during the early 1980's in the expected jury award was double or triple the entire increase in the prior twenty years.

The degree to which average jury awards have increased dramatically in recent years is further illustrated by the data published by Jury Verdict Research, Inc. While the Jury Verdict Research data are not inflation-adjusted and do not meet the same

²¹ Critics of the February, 1986 Report have argued that the average jury awards cited in the Report are "inflated" because they do not reflect cases in which defendants prevail before the jury. The argument misses the point, however, since the Report sought to document the trend of rapidly increasing jury awards. As long as the same categories of data (that is, plaintiffs' verdicts) are compared over time, the Report's conclusion as to the trend remains entirely valid. But since the Report did not reflect that plaintiffs steadily have increased the percentage of jury verdicts in which they prevail, the Report, if anything, understated the magnitude of the trend.

In any event, "expected award" data fully take into account those cases in which defendants prevail before the jury.

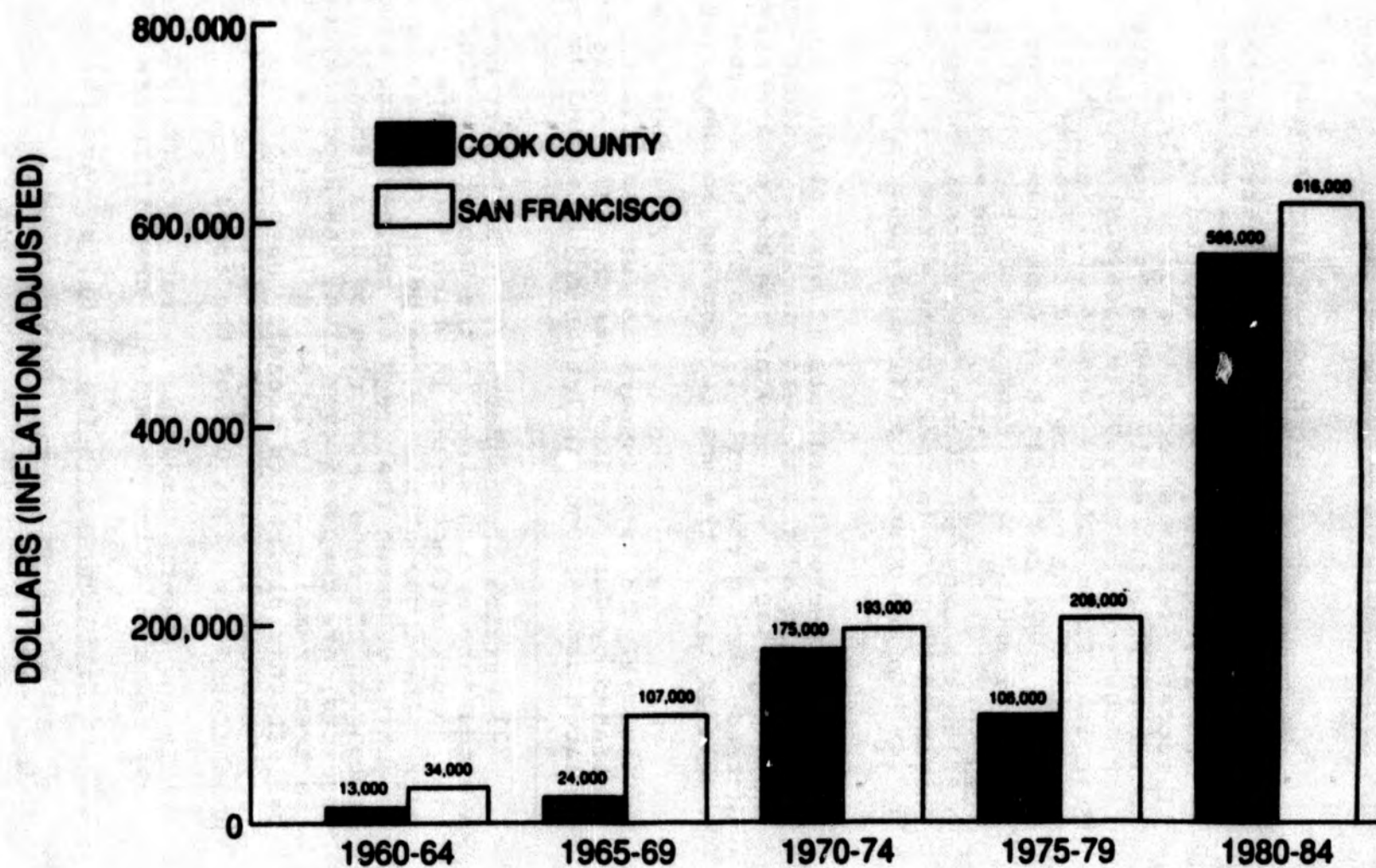
²² Civil Juries in the 1980s, at page 26.

²³ Id.

²⁴ Id., at page 35. As with the average jury verdicts, the expected awards are inflation-adjusted and expressed in 1984 dollars.

CHART F

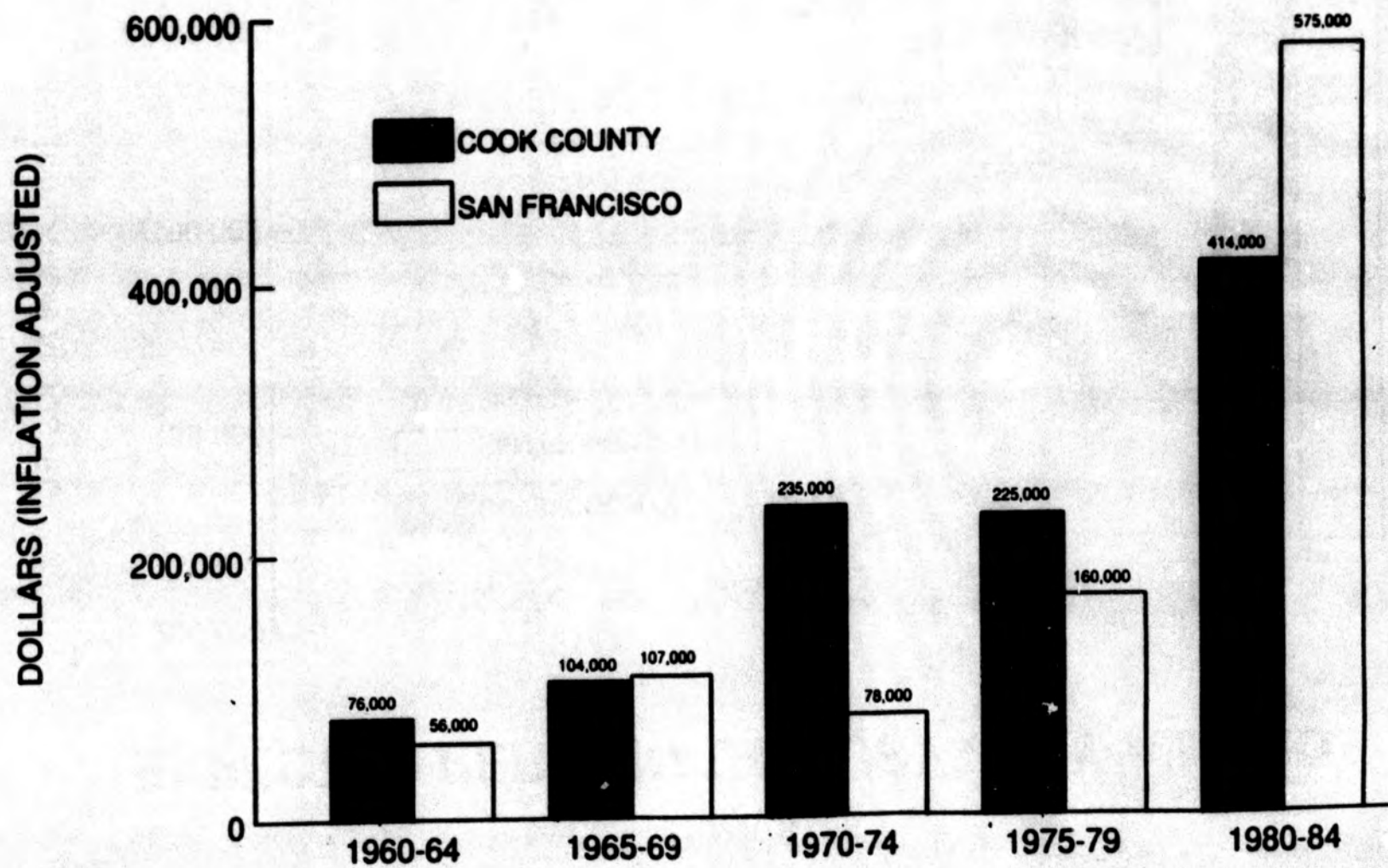
EXPECTED MALPRACTICE JURY AWARD



SOURCE: INSTITUTE FOR CIVIL JUSTICE

CHART C

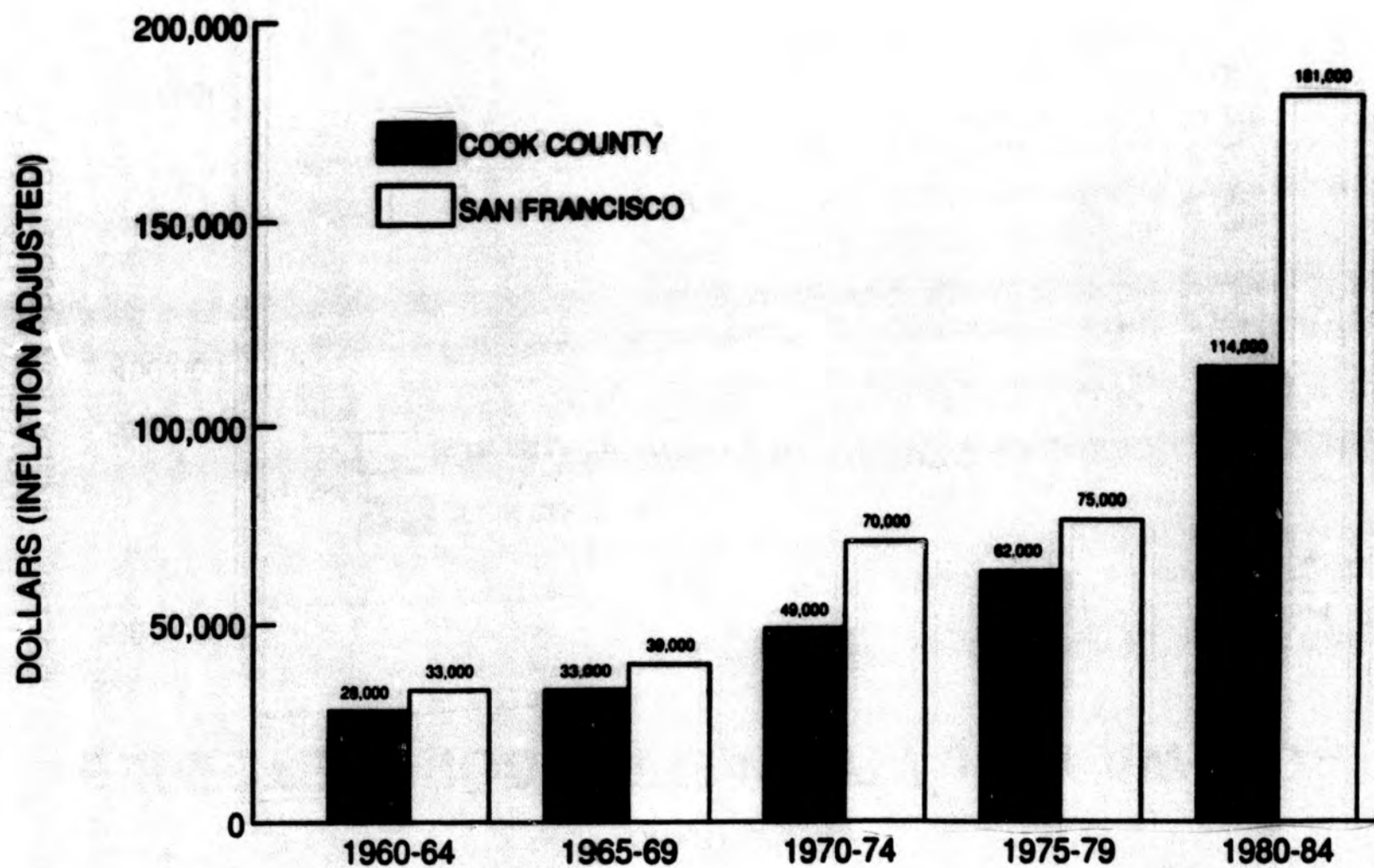
EXPECTED PRODUCT LIABILITY JURY AWARD



SOURCE: INSTITUTE FOR CIVIL JUSTICE

CHART H

EXPECTED PERSONAL INJURY JURY AWARD



SOURCE: INSTITUTE FOR CIVIL JUSTICE

rigorous methodological criteria used by the Institute for Civil Justice,²⁵ they also demonstrate an explosive trend in average verdicts. For example, the average medical malpractice jury award increased from \$220,018 in 1975 to \$2,056,525 in 1986, a 835% increase (see Chart I).²⁶ The average product liability jury award increased from \$393,580 in 1975 to \$1,971,655 in 1986, a 401% increase (see Chart J). Of particular interest is the fact that the average medical malpractice jury award grew by only \$184,708 from 1975 to 1980 but by \$1,651,799 from 1980 to 1986, while the average product liability jury award grew by only \$169,858 from 1975 to 1980 but by \$1,408,217 from 1980 to 1986. Clearly, the 1980's have been a period of extraordinary and unsurpassed growth in jury awards which has troubling implications for the stability of the entire tort system.

C. Million-Dollar Jury Awards

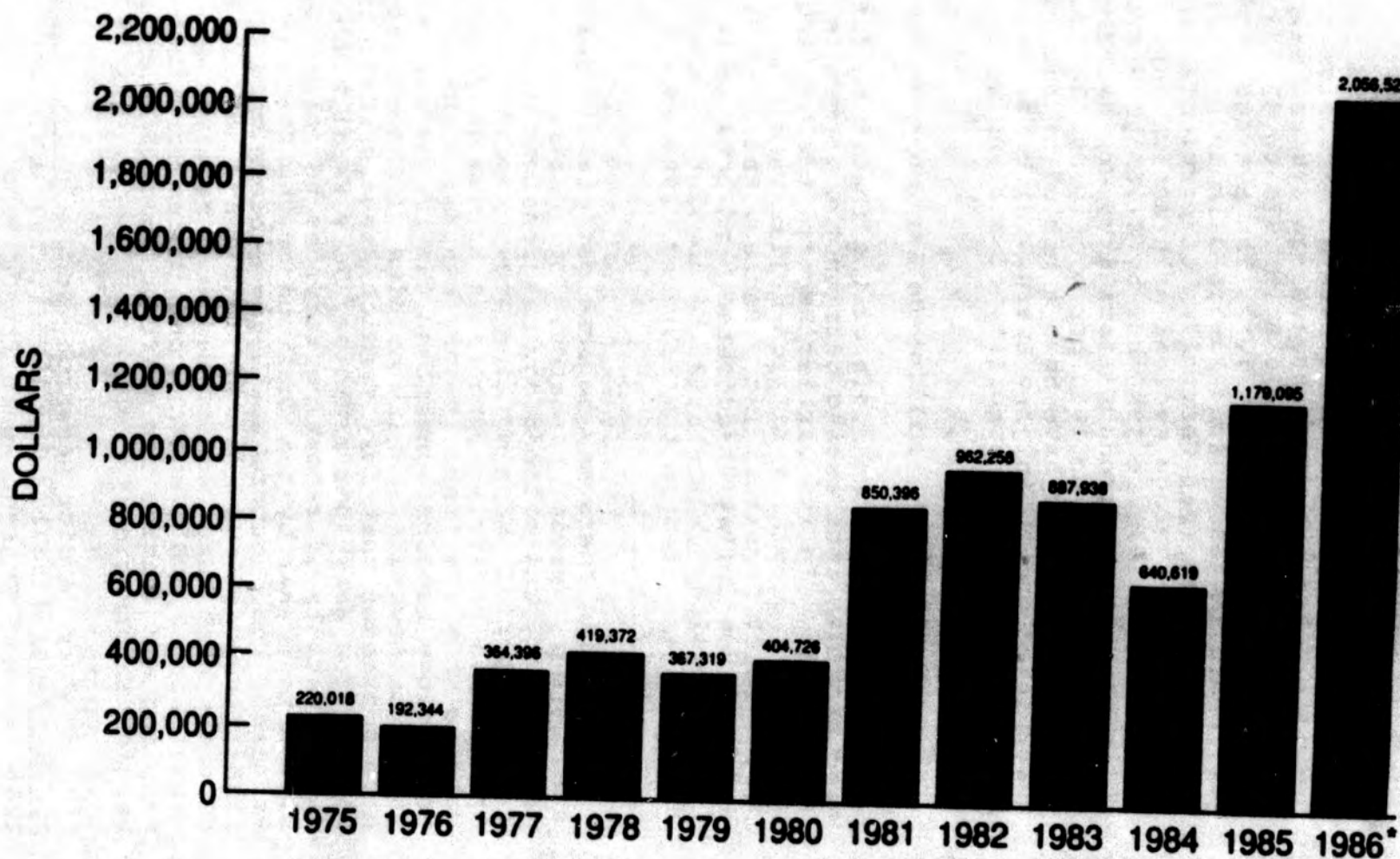
The empirical analysis of the Institute for Civil Justice also provides interesting data on the growth in million-dollar jury awards. In its earlier Report, the Working Group noted the substantial growth of million-dollar verdicts, as reported by Jury Verdict Research, Inc. Because the Jury Verdict Research data are not inflation-adjusted, and because it is likely that its methodology understates the absolute number of such verdicts, the data was cited in the February, 1986 Report not as a

²⁵ While there may be some deficiencies with the methodology used by Jury Verdict Research, Inc., as noted in the February, 1986 Report, the methodology has remained consistent over the relevant period. See Working Group Report, at page 35 n.33. Thus, it is entirely appropriate to use Jury Verdict Research data to show the trend in jury awards, since as long as its methodology remains consistent the trends derived from the data should be accurate. While critics of the February, 1986 Report have contended that Jury Verdict Research data are collected purely from newspaper articles, Jury Verdict Research in fact uses a variety of reporting services to obtain jury verdicts. As stated last year by the Chairman of the Board of Jury Verdict Research, Inc., before the House Subcommittee on Economic Stabilization: "We are confident that the data for the hundreds of cases that Jury Verdict Research receives and processes each week (about 2,000 a month) constitutes more than a representative sampling and enables our staff to compile valid statistical verdict information."

²⁶ Jury Verdict Research, Inc., Injury Valuation: Current Award Trends (1987). The 1975 to 1979 data can be found in the 1986 issue of Current Award Trends, and are summarized in the Working Group's February, 1986 Report, at pages 35-39. The award data for 1986 are incomplete and subject to refinement.

CHART I

AVERAGE MEDICAL MALPRACTICE JURY VERDICT

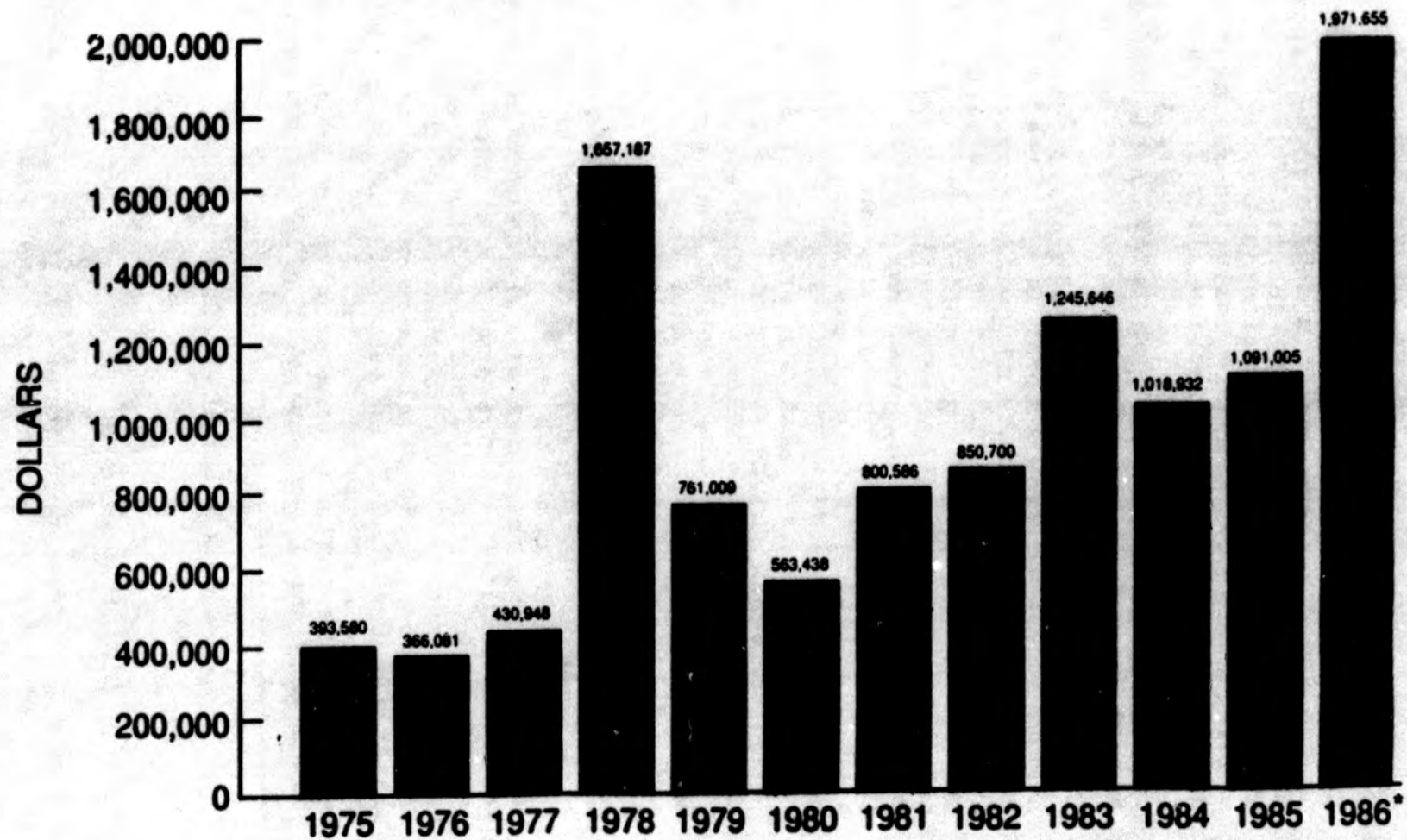


SOURCE: JURY VERDICT RESEARCH, INC.

* 1986 INFORMATION NOT COMPLETE

CHART J

**AVERAGE PRODUCT
LIABILITY JURY VERDICT**



SOURCE: JURY VERDICT RESEARCH, INC.

* 1986 INFORMATION NOT COMPLETE

statement of the absolute number of such verdicts, but primarily to demonstrate the rapid growth of "high-end" verdicts. As noted in the Report, these verdicts appear to be largely responsible for the recent extraordinary increases in average jury awards. The Institute's data on million-dollar verdicts are more meaningful in that they are inflation-adjusted (expressed in 1984 dollars), and appear to include all million-dollar jury awards in the analyzed jurisdictions. Not unexpectedly, the data clearly confirm a very substantial increase in million-dollar jury awards.

In Cook County, the analysis shows that million-dollar awards increased from a total of 2 in 1960-64 to 67 in 1980-84, while in San Francisco, such awards increased from a total of 5 in 1960-64 to 21 in 1980-84.²⁷ What is particularly important is the percentage of the total dollars awarded by juries that were awarded through verdicts of a million dollars or more. In Cook County, this percentage grew from only 4% in 1960-64 to 85% in 1980-84 (see Chart K),²⁸ while in San Francisco the percentage grew from 14% in 1960-64 to 58% in 1980-84.

The Institute's analysis also provides data on million-dollar personal injury awards as a percentage of all personal injury awards for the 1980-84 period (as noted, this category of cases also includes many lawsuits that typically involve lower monetary stakes). The data show that in Cook County 65% of the total dollars awarded by juries in all personal injury cases were awarded in verdicts of a million dollars or more, while in San Francisco the corresponding percentage was 47%.²⁹ What is particularly noteworthy is the small percentage of all tried personal injury cases which resulted in million-dollar awards. In Cook County, only 2.8% of all plaintiffs' personal injury jury verdicts resulted in an award of a million dollars or more, yet, as noted, those verdicts accounted for nearly two-thirds of the total of personal injury damages awarded by juries.³⁰ In San Francisco, only 3.8% of all personal injury verdicts for plaintiffs resulted in an award of a million dollars or more, yet those verdicts accounted for nearly half of the total damages awarded. The obvious conclusion to be drawn from this data is that a very small percentage of all tort cases account for a very

²⁷ Civil Juries in the 1980s, at page 33.

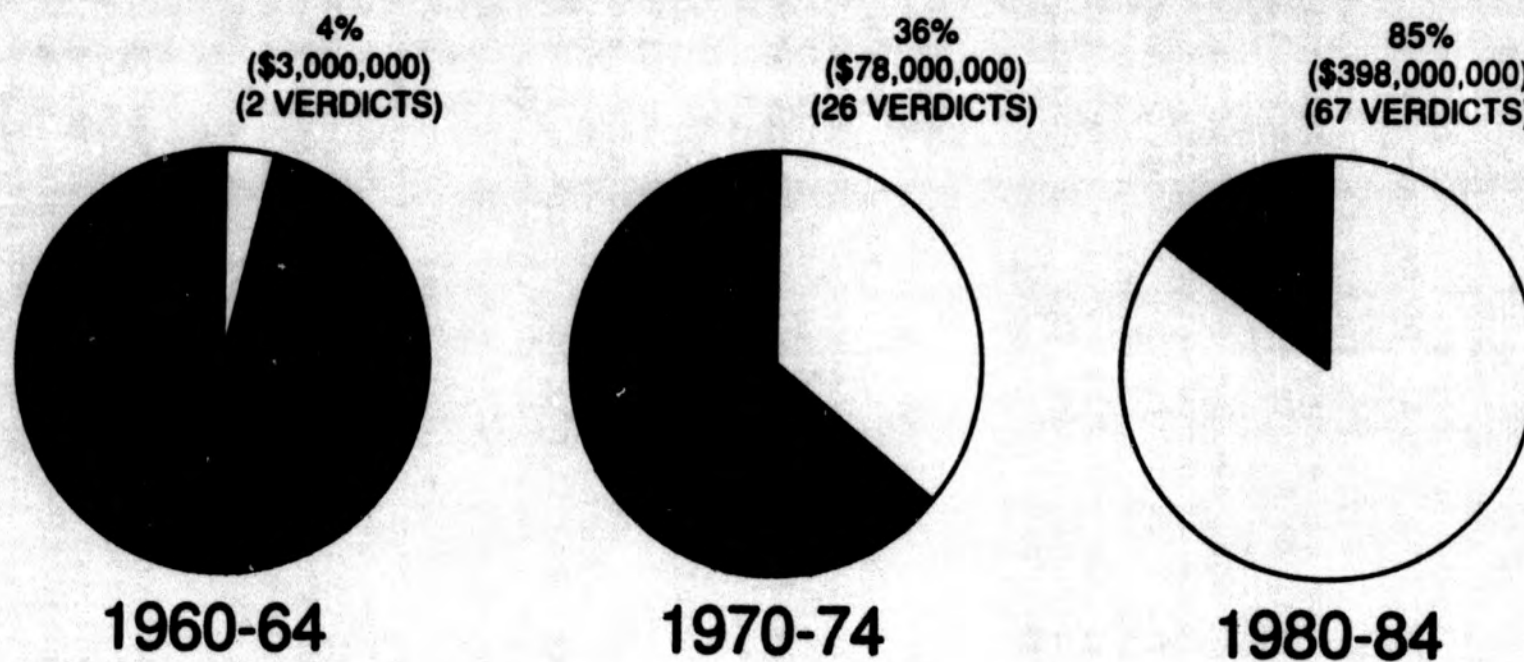
²⁸ Id.

²⁹ Id., at page 37.

³⁰ Id. As a percentage of all personal injury jury trials, including those in which defendants prevailed, million-dollar awards occurred in only 1.7% of all such trials. The corresponding percentage for San Francisco was 2%.

CHART K

**PERCENTAGE OF TOTAL DOLLARS*
AWARDED BY COOK COUNTY
JURIES ATTRIBUTABLE TO
MILLION-DOLLAR VERDICTS**



SOURCE: INSTITUTE FOR CIVIL JUSTICE

*INFLATION-ADJUSTED DOLLARS

large percentage of all awarded tort damages. Thus, it appears that much of the explosion in jury awards that has manifested itself so dramatically in recent years can be attributed in large part to a small percentage of all cases.

While the Institute's analysis does not distinguish economic from non-economic damages awarded in these "high-end" verdicts, available data suggest that much of the increase in awarded damages is in the form of non-economic damages -- that is, damages awarded for pain and suffering, mental anguish and other forms of nonpecuniary injury.³¹ Since non-economic damages are far more subjective and open-ended than economic damages,³² it should be by no means surprising that a sudden surge in damage awards would be largely attributable to a change in the non-economic rather than the economic components of such damage awards.

D. Median Jury Awards

Many of the critics of the Working Group's February, 1986 Report have focused on the Report's use of average (or mean) rather than median jury verdicts to illustrate the extraordinary growth in jury awards and its effect on insurance availability and affordability. Simply put, the average award is derived by dividing the total dollars awarded in a particular category of verdicts by the total number of such awards, while the median award is the dollar level at which half of the awards are at or below and the other half at or above. To illustrate, if there were three jury awards -- one for \$50,000, one for \$150,000, and one for \$1,000,000 -- their average would be \$400,000, while their median would be \$150,000.

³¹ Patricia Danzon, for example, in her analysis of medical malpractice damages, estimates that for jury awards involving more than \$100,000 in non-economic damages, on the average 80% of the entire award is for non-economic damages. See February, 1986 Working Group Report, at pages 67-68. She also estimates that non-economic damage awards in excess of \$100,000 account for between 28% to 50% of all paid out medical malpractice damages. Id.

³² While the valuation of components such as lost earnings and the cost of necessary medical care is a relatively straightforward process, compensation for pain and suffering, mental anguish and other forms of non-economic damages is wholly subjective and often varies greatly between cases involving similar injuries. Moreover, once economic damages are adjusted for inflation, the objective criteria used to determine these components should preclude large fluctuations over time. Non-economic damages, in contrast, are based on subjective criteria which can change dramatically over time.

Critics of the Working Group's Report have argued that median rather than average jury award data should be used to measure the change in jury verdicts, and that median data do not demonstrate a substantial change in verdicts over the past two decades.³³ They contend that average jury awards, by including a small number of "high-end" verdicts, provide a distorted picture.³⁴

The use of median data essentially obscures -- to the point of non-recognition -- the effect of "high-end" verdicts on the trend in jury awards. But, as noted, these "high-end" verdicts, while only a small percentage of all jury awards, represent a very large percentage of the total dollars awarded by juries.³⁵

³³ This often repeated assertion appears to be highly questionable. The recently published Institute for Civil Justice analysis shows a very substantial increase in inflation-adjusted median jury verdicts from the early 1960's to the early 1980's. For example, median malpractice jury awards increased in Cook County from \$35,000 in the early 1960's to \$121,000 in the early 1980's, with a corresponding increase in San Francisco from \$64,000 to \$156,000. Civil Juries in the 1980s, at page 22. Median product liability awards in Cook County increased from \$103,000 to \$187,000 during this period, with a corresponding increase in San Francisco from \$27,000 to \$200,000. Id. Jury Verdict Research data, which are not inflation-adjusted, show a very substantial increase during the 1980's in median jury awards for both medical malpractice (from \$200,000 in 1980 to \$515,000 in 1986) and product liability (from \$225,000 in 1980 to \$603,400 in 1986). For purposes of comparison, the Consumer Price Index during this period increased by 33%.

³⁴ See, e.g., Public Citizen, The Assault on Personal Injury Lawsuits: A Study of Reality Versus Myth; An Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance (1986) (prepared for the National Association of Attorneys General by a task force headed by former Attorney General of Massachusetts Francis X. Bellotti); P. Hermann & Jury Verdict Research, Inc., Report to the Subcommittee on Economic Stabilization of the Committee on Banking, Finance and Urban Affairs, U.S. House of Representatives (1986).

³⁵ For example, as noted, from 1980 to 1984, 2.8% of all Cook County personal injury jury awards accounted for two-thirds of all awarded personal injury damages, while 3.8% of all San Francisco personal injury awards accounted for nearly half of all such awarded damages. Thus, the use of median jury awards effectively would eliminate from a trend analysis the impact of one-half to two-thirds of all the damages awarded by juries.

Accordingly, median data substantially understate the growth of jury verdicts by eliminating or at least greatly obscuring the effect of the large awards which appear to be the major source of the problem. It is perhaps for that reason that critics of the Working Group's Report have so enthusiastically embraced the use of median rather than average verdicts in analyzing the growth of jury awards.

The simple answer to these critics, however, is that median data cannot, by their very nature, provide any meaningful insight into the relationship between tort damages and insurance premiums. Thus, to the extent one is analyzing jury award trends to assess the effect of those trends on insurance availability and affordability, median data simply are incapable of providing useful information.

An insurer calculating its premiums or a self-insurer setting aside liability reserves is interested in obtaining as accurate a projection as possible of its total liability. If it were to use projected median awards and settlements, it would most likely vastly underestimate its total liability since such data do not reflect the small number of "high-end" settlements and awards that account for a large percentage of its likely total payout. On the other hand, an accurate projection of the average award or settlement would allow the insurer or self-insurer to determine its actual exposure if it could also accurately project the number of settlements and awards it would have to pay.

A simple example illustrates this point. Let us assume that an insurer projects that it will have to pay four claims on a particular policy -- that three of those payments will be in the range of \$100,000, but that at least one payment will be for a million dollars. If it were to use the median payment (\$100,000) to calculate its premiums, the insurer would only collect sufficient premiums to cover a total payout of \$400,000 ($4 \times \$100,000$). If its projections proved correct, it would lose \$900,000 on the policy. On the other hand, if it based its premiums on the average payment (\$325,000), the insurer would collect sufficient premiums to cover the projected payout of \$1,300,000 ($4 \times \$325,000$). Assuming its projections proved correct, the insurer would break even.

Simply put, those who must pay the liability generated by the tort system cannot afford the luxury of using data which effectively ignore the cases which result in the largest payouts. Accordingly, it is virtually impossible to understand the effect (or even to appreciate the existence) of rapidly increasing settlements and awards on the availability and affordability of insurance if one relies on median data.

In sum, the recently published jury award data by the Institute for Civil Justice show an extraordinary growth in jury awards, much of which appears to have occurred in the 1980's.³⁶ The bulk of this growth seems to come from a small percentage of "high-end" verdicts that account for a very substantial percentage of all awards. Because such "high-end" verdicts tend to consist predominantly of non-economic damages, such damages appear to be the most significant contributing factor to this surge in jury awards.

II. Case Filings

Some critics of the Working Group's February, 1986 Report have contested the Report's conclusions regarding the increase in the number of product liability and medical malpractice lawsuits. The Report noted that the number of product liability actions filed in federal court from 1974 to 1985 had increased by 758%, and that federal district court medical malpractice actions had increased almost three-fold in the past decade.³⁷ In addition, the Report cited separate data showing a 123% increase in malpractice claims against physician-owned companies from 1979 to 1983, and a doubling of malpractice lawsuits per 100 physicians from 1976 to 1981³⁸ (with a tripling per 100 obstetricians/

³⁶ It is sometimes suggested that jury awards are irrelevant because only a small percentage of all claims result in a jury verdict, while most claims are settled before trial. But, as previously noted by the Working Group, "settlements by their very nature reflect the range of verdicts available to the plaintiffs. Thus, as jury verdicts skyrocket, so do settlements." Working Group Report, at page 49 n.56. The quoted passage goes on to observe that "[s]ettlements also reflect the plaintiff's likelihood of success." *Id.* As noted, the Institute's data show that plaintiffs have over the years increased their likelihood of success. Accordingly, the most accurate measure of the rate of increase of settlements probably is provided by expected award rather than by average award data.

³⁷ See Charts J (page 46) and K (page 48) of the February, 1986 Report.

³⁸ A recently published American Medical Association report indicates that, on average, claims per 100 physicians increased from 3.2 in 1980 to 10.1 in 1985. The Continuing Need For Legislative Reform of the Medical Liability System, at page 7 (1987).

gynecologists during the same period).³⁹ The Report also cited data showing a substantial increase in recent years in tort claims filed against municipalities (New York City, for example, witnessed a 375% increase between 1979 and 1983).⁴⁰

Nonetheless, these critics have denied that there has been any substantial increase in the number of filings, and have relied almost entirely in this assertion on a study published last year by the National Center for State Courts.⁴¹

A. The National Center for State Courts Study

The Center's study of tort lawsuits used State court data from thirteen States. Based on this data, the Center concluded that there had only been a nine percent increase in tort filings between 1978 and 1984, and that this increase roughly mirrored population growth (eight percent) during the same period. The Center thereupon concluded that there was no "litigation explosion."

At the outset, it must be noted that the Center's study has serious methodological deficiencies, particularly when compared to federal district court caseload data. The Center's study, for example, was limited to only thirteen States, and only two of those States (Kansas and Ohio) provided complete and unqualified data. Eleven of the surveyed States either did not provide tort data for all available courts, or provided data that were otherwise incomplete.⁴² In contrast, the federal data are

³⁹ These statistics are not, of course, limited to federal court filings. It is worth noting, however, that these numbers are entirely consistent with the federal district court caseload data.

⁴⁰ Working Group Report, at page 47.

⁴¹ National Center for State Courts, State Court Caseload Statistics: Annual Report, 1984 (1986).

⁴² Idaho, Alaska and Hawaii provided data from all available courts, but the data itself were incomplete. For example, while both superior court and district court data were obtained for Alaska, "low volume" district court data were not included. The Center did not clarify what constitutes a "low volume" district court case, and how many such cases are filed in Alaska. *Id.*, at table 33, p. 184. For Florida, the data do not cover all appropriate courts, and what is provided is incomplete. Specifically, the data for Florida contain circuit court statistics, but no data from the 67 county courts which can also

(continued...)

obtained from all ninety-four judicial districts throughout the United States, and are compiled and maintained in a consistent manner which facilitates comparison over time and among regions or States.

An example illustrates the incomplete nature of the Center's data. The Center's data on filings in California include only superior court filings, not filings from the 85 municipal courts. By using only the superior court data, the Center "found" only a 12% increase in tort filings between 1978 and 1984, identical to the increase in population. But, statistics from the 1976 and 1985 versions of the Annual Report of the Judicial Council of California, which include both superior court and municipal court filings, document an increase in civil tort filings between 1974 and 1984 of 55%, while the population only increased by 21% during this period.⁴³

There are other problems with the data used by the National Center for State Courts. The Center used only three snapshots of caseload statistics to substantiate its conclusions. It provided no information on the intervening years (1979, 1980, 1982 and 1983), and, of course, there is no pre-1978 or post-1984 data. Unlike the federal data, which span twelve years, with statistics for each year, the Center's data are, at best, barely adequate to identify trends. Simply put, the Center's use of a very limited number of discrete data points makes it difficult to determine whether those points actually represent trends or, instead, unknowingly focus on aberrations in the data attributable to other factors.⁴⁴

Even more importantly, however, the data used by the Center fail to account for the significant decrease in automobile accident lawsuits which has taken place in recent years. With

⁴²(...continued)

hear some tort cases. And even the Florida circuit court statistics do not include any "professional tort cases."

⁴³ The superior court filings may show a smaller increase than the combined filings because of an increase in the jurisdictional limits of the municipal courts from \$5,000 to \$15,000 in 1978.

⁴⁴ Thomas Marvell, in the May 19, 1986 issue of the National Law Journal, in an article entitled "There is a Litigation Explosion," highlighted the danger of trying to draw conclusions about trends from the limited data used by the National Center for State Courts. Marvell concluded that because of prevailing economic conditions, data from 1981 to 1984 could substantially understate long term litigation trends. He also concluded that "we can expect a very large increase [in civil filings] in 1986."

the advent of no-fault automobile liability insurance, and a nationwide decrease in the number of automobile-related injuries,⁴⁵ there has been a corresponding large reduction in automobile accident tort lawsuits.⁴⁶ Since automobile accident cases reflect the vast bulk of all tort filings⁴⁷, when these reductions are unaccounted for, they readily can mask substantial growth in other types of tort lawsuits, including product liability and medical malpractice actions. Because the Center's study provides no separate data as to areas of liability such as product liability, medical malpractice and municipal liability, but instead aggregates these claims along with all other tort claims (including automobile accident cases), the Center's report provides no information on the trend of filings in these particular areas of liability.

Thus, because the Center's study aggregates all tort filings, it is impossible to derive any credible conclusions from its study as to the growth in tort claims alleging product liability, medical malpractice, other forms of professional liability or municipal liability -- that is, the very areas of liability that have experienced serious insurance availability/affordability problems and which have been at the core of the debate over tort reform. Indeed, as noted, even a small reduction in filed automobile accident claims could more than mask a massive increase in lawsuits in these other areas of tort liability.

B. Federal District Court Caseload Data

Critics of the February, 1986 Report also have raised a number of other arguments regarding the federal district court data cited by the Working Group. They have suggested that the federal data are not meaningful because they represent only a small percentage of all filed tort claims, that the federal data

⁴⁵ Automobile-related injuries dropped from 2,000,000 in 1980 to 1,600,000 in 1984. Automobile-related deaths dropped from 51,100 in 1980 to 43,900 in 1984. Statistical Abstract of the United States, 1986, page 592.

⁴⁶ A Department of Transportation study indicates that implementation of some form of no-fault automobile insurance scheme, alone, resulted in reductions in automobile accident lawsuits of from 31% to 80%, depending upon the type of scheme and the jurisdiction. "Compensating Auto Accident Victims" (1985), pages 113-117.

⁴⁷ It is generally thought that, at least in the absence of no-fault automobile liability insurance, automobile accidents account for one-half to two-thirds of all tort lawsuits.

are somehow different or atypical, and that the statistics compiled by the Administrative Office of the United States Courts are skewed by a recent surge in removals and the fact that some cases may be counted more than once.⁴⁸ All of these assertions simply miss the mark.

While most tort cases in fact are filed in State court, federal court tort filings provide a valuable source of reliable data on the trend in the public's propensity to sue. For example, whether originally filed in federal court, or later removed there, federal district courts handle a significant number of product liability cases each year. In the twelve-month period ending June 30, 1985, over 9,000 non-asbestos related product liability suits were filed in federal court.⁴⁹ This, alone, represents almost a 500% increase over 1974. During the same period, total civil filings in federal court rose only 164%.⁵⁰ Obviously, whatever its share of total tort filings, district court product liability filings have risen at a rate which greatly exceeds the general rise in civil filings. To dismiss these figures, as some would suggest, simply because they represent a small percentage of all tort cases is specious.

As noted, critics also have claimed that the federal court statistics are inaccurate because they allegedly reflect a continued growth in removed cases and double or triple count transferred cases. These assertions are either completely wrong or insignificant. The percentage of civil filings in district court which are removals from State courts has remained virtually constant over the last ten years. Between 1976 and 1985 that percentage was never lower than 5.8% and never higher than 6.5%.⁵¹ Moreover, the number of civil filings which are original filings also has been remarkably steady. Original filings (that is, not transfers, removals, remands, etc.), have constituted between 88.1% and 89.6% of all federal civil filings for each of

⁴⁸ See Public Citizen, The Assault on Personal Injury Lawsuits: A Study of Reality Versus Myth (1986).

⁴⁹ Non-asbestos related claims are cited since it has been asserted that the asbestos litigations make federal product liability data unrepresentative. Id. While many asbestos injury claims in fact are filed in State courts, it should be noted that the deletion of asbestos related lawsuits does not appreciably alter the import of the federal data.

⁵⁰ Total civil filings in federal district court rose from 103,530 in 1974 to 273,670 in the twelve-month period ending June 30, 1985.

⁵¹ Annual Report of the Director of the Administrative Office of the United States Courts 1985, Table 17, page 136.

the last ten years. This consistency clearly repudiates the assertion that the growth in federal filings is attributable to any increased inclination to remove cases to federal court.

Nor is the assertion of multiple counting significant. While it is true that a case which is both originally filed and transferred to another district in the same year is included twice in the raw number of civil filings reported by the Administrative Office, the absolute number of such cases is, at best, minimal.⁵² More importantly, however, the percentage of civil filings which are transfers has been highly consistent over the years, and has never been high.⁵³ Equally consistent has been the combined percentage of civil filings which are either original filings or removals from State courts. These categories, which do not include any cases which are double counted, routinely have constituted 95% of all civil filings.

This consistency strongly corroborates the validity of the federal data when used to evaluate trends. There may be minor discrepancies between the raw numbers of "new" federal cases. But these discrepancies are statistically insignificant, and, in any event, have been present in each year's data. Accordingly, the Working Group's conclusions about the percentage growth in federal court litigation are absolutely valid.

In the absence of meaningful data on case filings in State court in areas such as product liability and medical malpractice, the federal district court data compiled by the Administrative Office of the United States Courts provide the most accurate data available on the growth in filed cases. While federal cases represent only a fraction of all tort cases in either of these categories, there is no reason to believe that they do not accurately reflect what is happening in the State courts. Despite its notoriety, the study of the National Center for State Courts simply does not provide the kind of meaningful data which justifies rejecting the obvious conclusions to be drawn from the very substantial increases in federal district court case filings.

⁵² The percentage of civil filings which were transfers in 1985 was less than 1.4%. Id. And, of these cases, only some were transferred in the same year as originally filed.

⁵³ That percentage hovered around 2% in the late 1970's, but actually decreased to about 1.5% in the first half of the 1980's. Id.

III. Punitive Damages

In its prior Report, the Working Group noted the extraordinary increase in recent years in the level of punitive damage awards. For example, the Working Group cited data published by the Institute for Civil Justice showing that the average punitive damage award has increased in Cook County from \$63,000 in 1970-74 to \$489,000 in 1980-84, while the average personal injury punitive damage award in Cook County increased from \$40,000 to \$1,152,174 during the same period.⁵⁴

The Working Group did not, however, recommend that punitive damages be abolished. Rather it recommended two reforms: that punitive damages be included within a cap on all non-economic damages; and, that the standard used for awarding punitive damages be one of actual malice.⁵⁵ As discussed in Chapter 4, a number of States in 1986 enacted legislation addressing punitive damages. In addition, punitive damages has been a key issue in the debate over tort reform, and was a particularly important element of the recent Senate consideration of a federal product liability bill.

While there are some who believe that punitive damages do not present a significant problem, there appears to be a growing consensus within the legal community that punitive damages indeed are in need of reform. For example, the Task Force on Litigation Issues of the American College of Trial Lawyers recently made the following statement on punitive damages.⁵⁶

The Task Force unanimously agrees that one of the greatest problems with the current tort system is the way in which punitive damages are handled. Awards often bear no relationship to deterrence and reflect a jury's dissatisfaction with a defendant and a desire to punish, often without regard to the true harm threatened by a defendant's conduct. There is a general feeling that punitive damage awards should be

⁵⁴ Working Group Report, at pages 39-42. The awards are inflation adjusted and expressed in 1984 dollars. The Institute recently has published a more thorough analysis of punitive damage awards, which not only reviews available data for Cook County and San Francisco, but also includes data for all of California for the 1980-1984 period. M. Peterson, S. Sarma & M. Shanley, Punitive Damages: Empirical Findings (1987).

⁵⁵ Working Group Report, at pages 68-69.

⁵⁶ Report of the Task Force on Litigation Issues, American College of Trial Lawyers, at page 4 (1986).

more difficult to obtain and that the amounts of such awards should be controlled much more than they are at the present time. . . . The most important reform should be to limit, either by a lid or some general formula (for example, three or four times actual damages), the amount of punitive damages that may be recovered.

Most recently, the American Bar Association House of Delegates approved the recommendation of its Action Commission to Improve the Tort Liability System regarding punitive damages. Among other proposals, the ABA recommends tightening both the standard of conduct and standard of proof necessary to obtain punitive damages, as well as giving judges the authority in certain cases to allocate part of such damages to public purposes.⁵⁷

Those who disagree with the proposition that punitive damages are a serious problem in need of reform generally base their argument on two assertions.⁵⁸ First, they contend that punitive damages have not really grown excessively if median rather than average award data are used. Second, they argue that because punitive damages are rarely awarded, and because the "typical" (that is, the median) punitive damage is not really that high, the problem has been overstated. Unfortunately, these critics do not appear to appreciate fully the nature of the problem.

At the outset, it should be noted that punitive damage awards, while generally infrequent, are not nearly as rare as often suggested. For example, the recent analysis by the Institute for Civil Justice indicates that the number of punitive damage awards in Cook County grew from 3 in 1960-64 to 75 in 1980-84, and in San Francisco grew from 14 in 1960-64 to 51 in 1980-84.⁵⁹ In San Francisco, almost one out of every seven

⁵⁷ The Action Commission originally recommended that all punitive damages be allocated to public purposes after paying "a reasonable portion of the punitive damage award to compensate the plaintiff and counsel for bringing the action and prosecuting the punitive damage claim." This recommendation was watered down in a compromise before being submitted to the House of Delegates.

⁵⁸ See, e.g., Public Citizen, The Assault on Personal Injury Lawsuits: A Study of Reality Versus Myth; An Analysis of the Causes of the Current Crisis of Unavailability and Unaffordability of Liability Insurance (1986) (prepared for the National Association of Attorneys General by a task force headed by former Attorney General of Massachusetts Francis X. Bellotti.)

⁵⁹ Punitive Damages: Empirical Findings, *supra*, at page 9.

The following is the Working Group's draft of a statutory formulation for an effective limitation on non-economic damages.

Limitation on Non-Economic Damages

- (a) Non-economic damages may not be awarded in excess of \$200,000 in any action subject to this Act.
- (b) For purposes of this section, "any action" includes all actions (including multiple actions) for damages, and includes all plaintiffs and all defendants in such actions, which arise out of or were caused by the same personal injury or death.
- (c) As used in this section, "non-economic damages" means all damages other than damages for economic loss, and includes punitive or exemplary damages. "Economic loss" means past and future (A) expenses of health or other care, (B) expenses of rehabilitation, (C) loss of earnings, (D) loss of homemaker services, and (E) burial expenses.

The limitation includes a definition of economic loss because of the concern expressed by some that courts hostile to a limitation on non-economic damages would create new forms of economic damages to substitute for limited non-economic damages.

III. Punitive Damages

As is obvious from the language of the above draft limitation on non-economic damages, the Working Group recommended in its prior Report that punitive damages be included within the overall limitation on non-economic damages. This remains the Working Group's preferred approach. While some have recommended a separate, perhaps higher, limitation for punitive damages, the Working Group is concerned that such an approach would lead courts and juries to award punitive damages as a way of circumventing a limitation on non-economic damages. Certainly, it would lead plaintiffs' attorneys to add punitive damage claims almost routinely to every claim (which, unfortunately, increasingly is the case anyway).

There are, however, alternative approaches that have considerable merit. One obvious reform is simply to abolish

punitive damages in all cases where the underlying claim for compensatory damages is based on negligence, malpractice or strict product liability. Historically, punitive damages arose in the context of intentional torts. It is only relatively recently that they have found their way into non-intentional tort actions. Restricting their application to intentional torts would simply return them to their traditional role in the tort system.

Another alternative is to limit punitive damages to a portion or multiple of plaintiff's awarded economic damages.¹³⁷ Such an approach would have the benefit of ensuring that the larger punitive damage awards are made to seriously injured plaintiffs.

A third alternative is to have all or virtually all of the award paid to the state to be used for public purposes. Since punitive damages are a windfall for the plaintiff and his attorney, there is much to be said for ensuring that this windfall accrues to the public. However, this approach is unprecedented in our legal system (although several States enacted such provisions last year), and may generate difficult problems of application and administration, particularly for the vast majority of cases settled out of court.

A fourth approach is to restrict attorneys' contingency fees to no more than 5% of any punitive damage award. While it is unlikely that such a restriction would prevent plaintiffs from seeking punitive damages where they are merited, it would reduce the incentive many plaintiffs' attorneys now have to pursue such claims at the cost of a reasonable settlement in their client's best interest.

The Working Group is relatively skeptical about the value of changing the standard of conduct or burden of proof which plaintiff must demonstrate to obtain punitive damages. While commendable, such changes are highly subjective, and thus quite susceptible to abuse. The recent increase in punitive damages has taken place, for the most part, with no articulated change in the doctrinal standard pursuant to which they are awarded. Accordingly, the Working Group believes that the most effective legislative approach to reforming punitive damages is to place some objective restriction on such damages, as discussed above. However, if the only possible reform is to address the required standard of conduct or burden of proof, the Working Group strongly recommends that punitive damage awards be restricted to

¹³⁷ The Working Group recommends that economic damages be used because the highly subjective nature of non-economic could lead to an inflated non-economic damage award to increase the punitive damage award.

cases where the plaintiff can demonstrate by clear and convincing evidence that the defendant acted with actual malice.¹³⁸

IV. Periodic Payments

The use of periodic payments for future economic damages can produce savings for the defendant or his insurer without depriving the plaintiff of anything to which he otherwise is entitled. Periodic payment provisions address those cases where the judge or jury have found that at some point in the future the injury suffered as a result of a defendant's conduct will cause the plaintiff to incur certain expenses or to forego certain income. The use of periodic payments simply allows these sums to be paid to the plaintiff as they accrue.

As a result, there should be little reason to oppose the availability of periodic payments when either party believes it to be a better course of action in a particular case. When cases are settled for large amounts, the parties frequently agree to structured terms which result in the payment of the settlement over a long period of time. There is no reasoned distinction for precluding the use of similar arrangements simply because the amount of damages has been determined by a jury instead of through a settlement.

There are several important criteria, however, to the effective use of periodic payments. First, their use should not be left to the court's discretion. Instead, they should be required, but only when at least one of the parties indicates that some form of periodic payments is desirable. It serves no purpose to require periodic payments in a case where neither party desires that they be used.

Second, whatever periodic payments schedule is fashioned, it must not be open-ended -- that is, it must not be subject to subsequent modification, except upon agreement of the parties. To allow either party to seek changes to the agreement from the court will quickly consume in additional litigation and transaction costs any savings that result from the use of periodic payments. In other words, a periodic payments provision should under no circumstances undermine the finality of the court's damage award.

Third, the Working Group continues to believe that periodic payments should not be imposed when future economic damages do

¹³⁸ Under an actual malice standard, the plaintiff must show that the defendant acted with an "evil motive," such as with an actual intention to inflict harm. See Smith v. Wade, 461 U.S. 30, 78 n.12 (1983) (Rehnquist, J., dissenting).

not exceed a certain minimum level. The Working Group recommends a minimum of \$100,000, though some States have set an even higher level.

Finally, such a provision should protect plaintiffs from the possible insolvency of defendants by permitting the court under appropriate circumstances to require the defendant to purchase an annuity providing the periodic payments.

The Working Group drafted the following provision which meets its criteria for periodic payments.

Periodic Payments of Judgments

- (a) In any action subject to this Act in which the damages awarded for future economic loss exceeds \$100,000, no person may be required to pay damages for future economic loss in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur.
- (b) The court may require such person to purchase an annuity making such periodic payments if the court finds a reasonable basis for concluding that the person may not make the periodic payments.
- (c) The judgment of the court awarding such periodic payments may not be reopened at any time to contest, amend, or modify the schedule or amount of the payments in the absence of fraud.
- (d) This section shall not be construed to preclude a settlement providing for a single, lump-sum payment.

V. Collateral Source Rule

The collateral source rule provides that a plaintiff's award may not be reduced by other sources of compensation the plaintiff receives as a result of the same injury. The Working Group sees no reason for why plaintiffs should be permitted to receive double compensation, particularly where part of the compensation is paid by the government. It simply makes no sense to require consumers of goods and services to pay higher prices to

compensate plaintiffs through tort settlements or judgments, and then to pay higher taxes to compensate plaintiffs a second time through government benefits for the same injury.¹³⁹

There are two important qualifications to the Working Group's position on the collateral source rule. First, it does not believe that collateral sources purchased purely by the plaintiff or his family should be included in the offset. Only benefits paid for in whole or in part by the government or by some independent source (such as the plaintiff's employer) should be treated as collateral sources to be offset from the tort award.

Second, the Working Group is concerned that existing subrogation rights not be lost. Thus, a collateral source offset ideally should not apply where there is a subrogated claim for restitution of the collateral source. This makes sense since a source of income is not really "collateral" if the plaintiff is required to reimburse the collateral source from the tort award.

Some have suggested that such subrogation proceedings, particularly as they apply to workers' compensation payments, involve such high transaction costs that it may be advantageous to prohibit subrogation in certain situations. Particularly in the context of product liability, there appears to be considerable support for the position that substantial resources would be saved by a prohibition on subrogation proceedings by employers against liable manufacturers as well as indemnification proceedings by liable manufacturers against employers. The reasoning is that such subrogation and indemnification lawsuits generate considerable attorneys' fees without providing much in the way of social benefit. Thus, it is argued that the prohibition of such suits would be a "wash" for employers and liable manufacturers while saving both sides substantial attorneys' fees.

The Working Group has considerable sympathy for this argument, and does not wish its position on subrogation to be understood as opposition to such an arrangement if mutually acceptable to both employers and manufacturers.

The following is the collateral source modification provision drafted by the Working Group.

¹³⁹ For this reason, the Working Group believes that an abolition of the collateral source rule should be in the form of a mandatory offset rather than a provision which merely allows evidence of collateral sources to be submitted to the jury.

Collateral Sources of Compensation

- (a) Any award of damages to a person in an action subject to this Act shall be reduced by the court by the amount of any past or future payment or benefit covered by this section which the person has received or for which the person is eligible on account of the same personal injury or death for which such damages are awarded.
- (b) As used in this section, "payment or benefit covered by this section" means --
 - (1) any payment or benefit by or paid for in whole or in part by any agency or instrumentality of the United States, a State or a local government, or
 - (2) any payment or benefit by a workers' compensation system or a health insurance program funded in whole or in part by an employer;but does not include any such payment or benefit that is (or by law is required to be) the subject of a reasonably founded claim of subrogation, reimbursement or lien.

VI. Attorneys' Contingency Fees

There is growing recognition that attorneys' contingency fees are a source of abuse that needs to be addressed. Even the American Bar Association House of Delegates recently adopted a recommendation that such fees be scrutinized more carefully.¹⁴⁰ But there continues to be substantial disagreement about how these abuses should best be addressed.

The Working Group believes that a sliding scale is the best and most equitable approach to dealing with the problem of excessive contingency fees. On the one hand, it ensures that contingency fees will be high enough to induce attorneys to take

¹⁴⁰ The tort reform recommendations recently adopted by the House of Delegates would, among other things, require that, upon a complaint by plaintiff, the fee arrangement and the bill be submitted to the court after judgment is entered, which would then have the power to disallow any "plainly excessive" fee in light of prevailing rates and practices.

smaller claims, while, on the other hand, precluding immense and unjustified windfalls to attorneys from very high verdicts and settlements. The Working Group believes that such a sliding scale will provide more than adequate compensation for attorneys, while significantly reducing the transaction costs that make tort litigation such an extraordinarily expensive dispute resolution system.

The Working Group does not believe that provisions that merely give greater discretion to courts to review contingency fees will be very effective. While some contingency fees undoubtedly would be reduced by some courts if given greater discretion to do so, such actions likely would be rare and would have virtually no impact on the overall cost of tort litigation.

The following is the provision drafted by the Working Group on attorneys' contingency fees.

Attorneys' Contingency Fee Arrangements

- (a) An attorney who represents, on a contingency fee basis, a person bringing an action subject to this Act may not charge, demand, receive or collect for services rendered in connection with such action in excess of 25 per centum of the first \$100,000 (or portion thereof) recovered, plus 20 per centum of the next \$100,000 (or portion thereof) recovered, plus 15 per centum of the next \$100,000 (or portion thereof) recovered, plus 10 per centum of any amount in excess of \$300,000 recovered by judgment or settlement in such action.
- (b) As used in this section, "contingency fee" means any fee for professional legal services which is in whole or in part contingent upon the recovery of any amount of damages, whether through judgment or settlement.
- (c) In the event that such judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the attorney contingency fee shall be based on the cost of the annuity or trust established to make payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

CHAPTER 6

THE RELATIONSHIP OF TORT REFORM TO INSURANCE AVAILABILITY AND AFFORDABILITY

In its Report of last year, the Working Group recommended eight reforms of tort law. The Working Group felt that these eight reforms "would bring a greater degree of rationality and predictability to tort law, and thereby significantly assist in resolving the availability and affordability crisis."¹⁴¹ The Working Group recognized that its list of recommended reforms was by no means exhaustive, but concluded that their adoption would result in "a more predictable and affordable liability allocating mechanism."¹⁴²

The eight reforms recommended by the Working Group were:

- o Return to a fault-based standard for liability.
- o Base causation findings on credible scientific and medical evidence and opinions.
- o Eliminate joint and several liability in cases where defendants have not acted in concert.
- o Limit non-economic damages (such as pain and suffering, mental anguish, or punitive damages) to a fair and reasonable maximum dollar amount.
- o Provide for periodic (instead of lump-sum) payments of damages for future medical care or lost income.
- o Reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery.
- o Limit attorneys' contingency fees to reasonable amounts on a "sliding scale." And,
- o Encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

¹⁴¹ Working Group Report, at page 60.

¹⁴² Id.

As related in Chapter 4, a number of States enacted tort reform proposals in 1986, many of which addressed the same problems identified by the Working Group. Recently, however, there has been a growing sense of frustration in some quarters that these enacted reforms have not been followed by immediate substantial rollbacks in the price of insurance. In some instances, the insurance market has tightened even further despite the enactment of tort reform legislation. Not surprisingly, opponents of tort reform have seized upon these events to claim that tort reform has no effect on insurance availability or affordability. But even some strong supporters of tort reform have expressed their disappointment at the fact that insurance prices have not responded more rapidly to the enactment of tort reform legislation.

Unfortunately, the reality is that the deterioration of our civil justice system is a long-term problem, and that any legislative reforms simply will not cure that deterioration overnight. While the impatience and frustration of those who expect immediate results is understandable, it also is unrealistic. There are several important, inescapable reasons for why tort reforms take time to affect insurance availability and affordability, and it is crucial to the national debate on tort reform to understand those reasons.

One important reason that enacted tort reforms frequently do not have an immediate impact on insurance is the time consuming process of determining their constitutionality. It can take years, perhaps a decade or more, before the highest court of a State renders its opinion on the constitutionality of a particular tort reform provision. For the plaintiffs' bar, tort reform is a two-front war -- the first front is the State legislature, but any loss there still can (and usually will) be challenged in the courts.¹⁴³

The time consuming nature of such constitutional litigation is amply demonstrated by California's experience. In 1975 California enacted a set of comprehensive medical malpractice reforms, entitled the Medical Injury Compensation Reform Act of 1975 (MICRA). These reforms were immediately challenged in the

¹⁴³ The September 5, 1986 issue of Business Insurance reported that the American Trial Lawyers Association has established a Constitutional Challenge Committee to coordinate efforts to overturn legislative tort reforms. The article indicates that, among other things, the Committee will provide legal research assistance as well as model briefs. Id., at page 1. For a discussion of various theories and cases challenging tort reforms on State and federal constitutional grounds, see Smith, "Battling a Receding Tort Frontier: Constitutional Attacks on Medical Malpractice Laws," 38 Okla. L. Rev. 195 (1985).

courts, and not until nearly a decade later did the California Supreme Court (by a four to three vote) and the United States Court of Appeals for the Ninth Circuit uphold the constitutionality of the statute. Fein v. Permanente Medical Group, 38 Cal.3d 137, 695 P.2d 665 (1985);¹⁴⁴ Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985).

Insurers, of course, are well aware of such constitutional challenges, and of the fact that many such challenges against the medical malpractice statutes enacted in the mid-1970's were relatively successful. They also are aware that if a particular tort reform provision is declared unconstitutional, their liability will be determined on the basis of pre-existing law, even if the insurance premium was calculated on the basis of the reformed law. Accordingly, many insurers are reluctant to write policies which take tort reforms completely into account until those reforms have been found to be constitutionally valid.

A second factor which often delays the impact of tort reform is the process of judicial construction and application. Frequently, even where the reform is thought to be constitutional, there is sufficient ambiguity in the statutory language to allow courts great leeway in construing and applying the statute. Unfortunately, judges opposed to tort reform often are quite creative in interpreting reform provisions so as to reduce or even virtually eliminate their effect. Other times, however, the problem can be traced to poor legislative draftsmanship and unclear or contradictory legislative history. Thus, many tort reforms provisions are sufficiently confusing or ambiguous (or have minor ambiguities which are exploited by opponents of the provision) that their meaning often can only be determined after years of litigation.

Obviously, the process of judicial construction and application can delay the impact of tort reform legislation for years. Just as insurers are reluctant to write policies on the basis of statutes that may be declared unconstitutional, they also are reluctant to write policies on the basis of statutes whose meaning is ambiguous and whose effect may be eviscerated through hostile judicial interpretation.

A third reason tort reform provisions often take time to have their desired effect on insurance rates is that the impact of some reforms can only be determined through experience. The effect of certain reforms, such as a cap on liability or an offset of collateral sources of compensation, should be

¹⁴⁴ The United States Supreme Court, in declining to review Fein, held that the decision did not raise a substantial federal question. Fein v. Permanente Medical Group, ___ U.S. ___, 106 S.Ct. 214 (1985).

relatively easy to "cost out." The likely savings from other reforms, however, particularly those directed at changing standards of liability or proof, use of alternative dispute resolution, tightening of sanctions for frivolous or abusive litigation, and regulation of attorneys' fees, are far more difficult to assess. In essence, the insurer must make behavioral judgments about plaintiffs, juries and attorneys that are inherently speculative. For example, to what extent does a more rigorous burden of proof (such as the use of "clear and convincing" rather than "preponderance of the evidence") affect the willingness of a plaintiff to bring a claim, or the willingness of his or her attorney to settle the claim, or, most importantly, the final determination of a jury? These are critical questions which are extraordinarily difficult to answer in the abstract.

Insurers often are reluctant to make such abstract behavioral judgments. Where possible they try to base their underwriting decisions on actual claims experience, and such claims experience can accumulate for several years before it provides meaningful insights. That is not to say that insurers cannot and do not attempt to assess the impact of tort reforms without the benefit of detailed claims experience. It is to say, however, that many insurers are unwilling to assume large (and sometimes optimistic) savings on the basis of behavioral assumptions for which there is no corroborating claims experience.

It also is important to note that tort liability is only one factor -- albeit the most important factor -- which determines the price of insurance. There are other considerations which also change over time, such as the prevailing interest rates, the return available from investment securities, State regulatory practices (including reserve requirements), and taxes, which affect the price of insurance. If some or all of these considerations exert upward pressure on the price of insurance, tort reform provisions may do no more in the short-term than to reduce the rate of premium increases.

Finally, the effect of many tort reforms may be obscured by the continuing deterioration of other aspects of the tort system which have not been reformed. Thus, for example, a mandatory offset of collateral benefits may achieve substantial savings, but those savings may be overwhelmed by continuing increases in non-economic damage awards. The collateral benefit reform may have reduced the price of insurance over what it otherwise would have been, but due to other aspects of tort law, the price of insurance nonetheless may have increased, perhaps even substantially.

None of the above should be interpreted to mean that tort reform does not affect the availability and affordability of

insurance. To the contrary, as discussed below, there is persuasive evidence of such an effect. But the above considerations indicate that the impact of tort reform often can be very difficult to ascertain in the short-term, even if its long-term impact can be quite substantial.¹⁴⁵

While there is some anecdotal evidence showing that the tort reforms enacted in 1986 already are having an impact on insurance availability and affordability,¹⁴⁶ it is far too early to have any solid statistical evidence demonstrating the existence and extent of the impact of these reforms on the insurance market. There is, however, a body of data which is quite useful in documenting the link between tort reform and insurance. This body of data can be derived from the medical malpractice reforms of the mid-1970's, which have been in place (at least in those States where their constitutionality has been upheld) long enough to provide some useful information.

Recently, the General Accounting Office (GAO) studied six State medical malpractice statutes and their affect on claims and

¹⁴⁵ The Report of the Governor of New York's Advisory Commission on Liability Insurance provides a synopsis of the practical and methodological difficulties inherent in trying to quantitatively document a direct link between specific tort reform measures and insurance pricing. Insuring Our Future, Vol. II, at pages 58-70. Despite these limitations, the Commission was sufficiently persuaded of the link between tort reform and liability insurance to recommend significant tort reforms as part of its overall solution to the liability insurance crisis. Id., at pages 70-180.

¹⁴⁶ For example, it has been reported that, as a result of the tort reforms enacted in Connecticut in 1986, the Hartford Insurance Group has reduced its liability insurance premiums for Connecticut municipalities by as much as 10%; Aetna Life and Casualty has agreed to freeze its liability rates for Connecticut policyholders; and, Fireman's Fund has started to underwrite certain risks for the first time. The elimination of joint and several liability in Wyoming has caused at least one company to lower its municipal liability insurance premiums in that State by 10%. And in New Hampshire, recent tort reforms are reported to have resulted in a 16% decrease in liability rates for both municipalities and day care centers.

In other States, such as Alaska, Colorado and Washington, insurance companies are expressing a willingness to expand their underwriting in certain areas, and even to return to markets that previously had been abandoned as uninsurable. In each case, the reason for this increased availability has been attributed to the tort reforms enacted in those States.

the cost of medical malpractice insurance.¹⁴⁷ Of particular interest is the comparison between California, which enacted a very rigorous medical malpractice statute in 1975,¹⁴⁸ and Florida and New York, which enacted substantially weaker reforms in the mid-1970's.¹⁴⁹

The three States are useful for purposes of comparison since all three are highly urbanized,¹⁵⁰ and have large populations and substantial insurance markets. It is worth noting that of the three, California has the tort system most generally advantageous to plaintiffs. Indeed, the California Supreme Court has for many years been one of the most activist courts in the Nation in developing new tort liability theories, and has issued many of the seminal opinions which have undermined the role of fault and causation in determining liability. MICRA, on the other hand, is one of the most rigorous medical malpractice statutes in the United States. See footnote 148, *supra*.

The GAO study provides the following data as to the increase in malpractice insurance rates during the 1980's.

¹⁴⁷ GAO, Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (1986). The six analyzed States were Arkansas, California, North Carolina, Florida, Indiana and New York. The GAO also issued a separate report covering each State. The title of the summary report is somewhat unfortunate, since it suggests tort reform may not affect insurance costs. In fact, the data contained in the report lead to precisely the contrary conclusion. And as already discussed, there are a number of factors that determine the cost of insurance, including aspects of tort liability which were not reformed in some or all of the six selected States.

¹⁴⁸ The California statute, MICRA, has been described by many in the medical community as a model malpractice reform statute. Its key provisions are a \$250,000 cap on non-economic damages, a sliding scale on attorneys' contingency fees which limits the attorney to 10% of any amount over \$200,000, and a periodic payment requirement. The New York and Florida statutes enacted in the mid-1970's are significantly weaker in comparison.

¹⁴⁹ Both Florida and New York enacted more rigorous tort reforms in 1985 and 1986. As noted, however, it is still too early to draw any conclusion from those statutes.

¹⁵⁰ Patricia Danzon has found that urbanization is "the single most important factor contributing to interstate differences in malpractice claims." P. Danzon, New Evidence on the Frequency and Severity of Medical Malpractice Claims, 17 (Institute for Civil Justice, 1986).

**Percent Increase in Malpractice Insurance
Rates for Selected Specialties Between
January 1, 1980 and January 1, 1986**

	<u>California</u>	<u>Florida</u>	<u>New York</u> ¹⁵¹
General Practice	173%	199%	335%
Internal Medicine	61%	199%	326%
General Surgery	88%	256%	175%
Anesthesiology	35%	217%	96%
Obstetrics/ Gynecologists	140%	395%	345%
Orthopedic Surgery	88%	198%	216%
Neurosurgery	113%	370%	273%

While all three States witnessed an increase in the cost of medical malpractice insurance from 1980 to 1986, both New York and Florida far outstripped California. Particularly in the two high litigation risk specialties (obstetrics/gynecologists and neurosurgery), the difference between California, on the one hand, and New York and Florida, on the other, is stark. For both of these specialties, the percentage rate of increase in insurance premiums was two to three times greater in Florida and New York than in California.

These findings are consistent with a 1985 report to the New York Medical Society.¹⁵² Among other things, the report contains data on the 1985 premiums for a \$1,000,000/\$3,000,000 malpractice insurance policy,¹⁵³ as well as the size of the premiums as a percentage of physician net income and gross revenue.

¹⁵¹ The New York data did not include Nassau, Suffolk, Bronx, Kings, Queens, Richmond, Rockland, Sullivan, New York, Orange, Ulster or Westchester Counties. Interestingly, some of these counties reportedly have had among the most substantial insurance problems in New York State.

¹⁵² Report to the Medical Society of the State of New York, An Analysis of Medical Malpractice Insurance Expenses and Physician Income in New York and Selected States, prepared by Healthscope Management Services Corporation in association with the Center for Health Policy Studies (1985).

¹⁵³ The premium data in the report to the New York Medical Society show substantially higher premiums for New York physicians than the data collected by the GAO. The most likely explanation for the difference is that the GAO data do not include a number of New York counties that reportedly have experienced serious insurance problems. See footnote 151, *supra*.

1985 Premiums

	<u>Malpractice Insurance Premiums</u>	<u>Premiums as a Percentage of Net Income</u>	<u>Premiums as a Percentage of Gross Revenue</u>
All Physicians			
California	\$10,547	9.5%	5.0%
Florida	\$16,018	11.9%	6.6%
New York	\$17,109	18.0%	10.2%
Obstetrics/ Gynecology			
California	\$36,685	27.7%	13.6%
Florida	\$57,781	38.5%	20.9%
New York	\$51,420	51.6%	23.5%

Both the GAO study and the report to the New York Medical Society show quite clearly that California physicians have fared substantially better than their Florida or New York colleagues as far as the cost of their malpractice insurance. Not only is the absolute cost of medical malpractice insurance significantly lower in California, but perhaps even more importantly from the standpoint of showing the link between tort reform and malpractice, the rate of premium increases has been far more moderate in California. The inescapable conclusion is that MICRA has had a very substantial impact on the cost of medical malpractice insurance for California physicians.

Two useful conclusions can be drawn from the above data applicable to more general tort reform efforts. First, strong tort reform measures that rigorously address the problems of tort law -- such as California's MICRA -- can have a very real and substantial effect on insurance costs. Second, weak tort reform measures -- such as the medical malpractice statutes enacted in Florida and New York in the mid-1970's -- probably will have only a very limited impact on insurance availability and affordability.

There also are some important additional observations on the link between tort reform and insurance availability and affordability. One observation is that patience is important; tort reform works, but only if given time. And, obviously, the sooner reforms are enacted, the sooner they will begin to have their effect on the insurance market. A second critical observation is that tort reform statutes will be far more effective, and achieve their purposes more quickly, when they are

drafted clearly with all ambiguities resolved prior to enactment. Finally, and perhaps the most important consideration, the ultimate success of tort reform measures depends greatly on the sensitivity of the courts to the legitimate need for and very real benefits of such legislation. The natural inclination of many judges is to oppose tort reform. And judicial hostility to tort reform can defeat, or, at a minimum, substantially delay the implementation of even the most necessary and popular reforms of the civil justice system. In this regard, the recent success of MICRA before the California Supreme Court, the United States Court of Appeals for the Ninth Circuit, and the United States Supreme Court, suggests that the courts may be much more receptive to such legislation than in the recent past.

CONCLUSION

While there are a number of conclusions and recommendations contained within this Report, the following are the Working Group's primary conclusions regarding the insurance and liability crisis and the appropriate response of the federal government to that crisis.

First, the crisis in insurance availability and affordability, while substantially ameliorated, continues to impose significant costs on much of the American economy. The effects of the crisis likely will be felt throughout the economy -- particularly in certain sectors -- for some time to come.

Second, tort liability is a key underlying reason for the crisis in insurance availability and affordability. Its contribution to the crisis is two-fold: rapidly expanding liability, including dramatically higher damage awards, have substantially increased the cost of the tort liability system; and, changing doctrinal standards have significantly heightened the uncertainty and unpredictability of the tort system, and thereby have exacerbated the already serious problems of the system.

Third, legislative tort reforms are a reasonable, legitimate and effective response to many of the deficiencies of tort law. Such legislation, however, is by no means the only answer to the problems of the tort system; much of the responsibility for improvement remains with the courts.

Fourth, rigorous and meaningful tort reforms can have a real impact on insurance availability and affordability if given the opportunity and sufficient time to work.

Fifth, the Working Group continues to believe that there is no justification or need for federal insurance regulation or the creation of federal insurance or indemnification programs.

Sixth, there is an appropriate role for federal tort reform legislation in those areas where there is a compelling federal interest. Such areas include product liability, the liability of federal government contractors, and the tort liability of the federal government and its employees.

Seventh, the Administration should continue to support and work actively with Governors and State legislators to achieve reasonable and workable tort reforms at the State level. And,

Eighth, the Working Group continues to believe that the eight tort reforms recommended in its prior Report represent the most sensible and effective potential reforms of the American civil justice system.

APPENDIX

THE CRISIS IN PROPERTY-CASUALTY INSURANCE

Antitrust Division, United States Department of Justice

Extensive debate continues as to the causes of the crisis in property-casualty insurance. The crisis is manifested by serious problems in affordability, availability, or both, in several lines. In most of those lines, these problems are of relatively recent origin. This report describes and evaluates the most commonly alleged causes of the crisis.

The Antitrust Division's preliminary economic assessment indicates that three of the four most commonly alleged causes of the crisis--collusion among insurers, imprudent business practices and declines in investment income, and state regulation--all are unlikely to have caused the crisis. In contrast, both theoretical economic analysis and empirical evidence support the conclusion that unanticipated changes in the manner in which tort liability has been established and damages assessed, along with the uncertainty engendered by these changes, are directly responsible for the current affordability and availability problems in property-casualty insurance.

I. Collusion

It has been asserted that a principal cause of the crisis has been concerted, anticompetitive actions by insurers to raise prices in certain lines of property-casualty insurance or even to refuse to write such insurance. Economic analysis of the relevant insurance markets, however, leads to the conclusion that such a scenario is implausible.

A. The Legal Environment for Collusion

A major purpose of the antitrust laws is to deter concerted pricing and marketing decisions among competitors. Certain types of collusive conduct, particularly agreements to raise price and restrict output, are illegal per se and expose the participants to both severe criminal sanctions and civil

actions for treble damages by injured parties. In the insurance area, however, the McCarran-Ferguson Act ^{1/} provides a limited antitrust exemption for the business of insurance.

The McCarran-Ferguson Act of 1945 was a response to a Supreme Court decision that held that the business of insurance was within the regulatory power of Congress under the Commerce Clause and, thus, was subject to the antitrust laws. ^{2/} The Act secured the primacy of the states in the regulation and taxation of the business of insurance: it delimited the influence of the federal government, relegating only a residual role to the federal antitrust laws. Under the Act, the Sherman, Clayton, and Federal Trade Commission Acts apply to the business of insurance only to the extent that such business is not regulated by state law, ^{3/} or if the challenged conduct involves boycott, coercion, or intimidation. ^{4/}

Because the McCarran-Ferguson exemption is premised on state regulation, however, its net immunizing effect is more limited than otherwise might be supposed. There appears to be a substantial overlap between the McCarran-Ferguson exemption and another antitrust exemption, the "state action doctrine," which holds that the federal antitrust laws do not prohibit anticompetitive conduct properly attributable to the states rather than to private parties. ^{5/}

Recent state action cases have established a two-pronged test for determining whether private anticompetitive conduct that restrains competition is entitled to state action immunity. The restraint must be the product of a "clearly articulated and affirmatively expressed" state policy to displace competition, and the state must actively supervise any private anticompetitive conduct. ^{6/}

^{1/} 15 U.S.C. §§ 1011-1015.

^{2/} United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944).

^{3/} 15 U.S.C. § 1012(b).

^{4/} 15 U.S.C. § 1013(b).

^{5/} See Parker v. Brown, 317 U.S. 341 (1943).

^{6/} California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

In its 1985 Southern Motor Carriers decision, 7/ the Supreme Court held that a state need not "compel" private anticompetitive conduct in order to satisfy this test. In that case, state regulation of collective ratemaking by intrastate motor carriers was considered sufficient. Thus, Southern Motor Carriers suggests that at least some forms of state insurance regulation could protect concerted decisions among insurers from antitrust liability, even if the McCarran-Ferguson exemption did not exist.

While Southern Motor Carriers may have narrowed the difference between McCarran-Ferguson immunity and state action immunity, significant distinctions remain. The McCarran-Ferguson Act applies only to conduct that constitutes the "business of insurance" within the meaning of the Act, 8/ whereas the state action doctrine is potentially applicable to any conduct regulated by the states. Also, states may regulate some insurer conduct in a manner that is sufficient to trigger the McCarran-Ferguson exemption, but not sufficient to provide state action immunity. For example, it has been held that states do not have to regulate the specific practices challenged under the antitrust laws for the McCarran-Ferguson immunity to attach:

Unless the practice amounts to a boycott, the states are free to regulate it or choose not to regulate. They do not have to expressly authorize a specific activity, or proscribe it, for the exemption to apply. . . . It is enough that a detailed overall scheme of regulation exists. 9/

7/ Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48 (1985).

8/ Not all insurer conduct necessarily constitutes the "business of insurance." See, e.g., Group Life & Health Insurance Co. v. Royal Drug, 440 U.S. 205 (1979).

9/ Klamath-Lake Pharm. v. Klamath Med. Serv. Bureau, 701 F.2d 1276, 1287 n.10 (9th Cir.), cert. denied, 464 U.S. 822 (1983) (citations omitted). See also Addrisi v. Equitable Life Assur. Soc., 503 F.2d 725 (9th Cir. 1974), cert. denied, 420 U.S. 929 (1975); Mackey v. Nationwide Ins. Companies, 724 F.2d 419 (4th Cir. 1984); Commander Leasing Co. v. Transamerica Title Ins. Co., 477 F.2d 77 (10th Cir. 1973); Feinstein v. Nettleship Co., 714 F.2d 928 (9th Cir. 1983), cert. denied, 466 U.S. 972 (1984).

Without a detailed, state-by-state analysis of regulation in the crisis lines, however, it is difficult to assess the extent to which concerted insurer decisions would enjoy state action immunity from the antitrust laws. Antitrust immunity by itself, however, does not necessarily imply that insurance providers are currently colluding: Even in the absence of legal prohibitions, the structure of the market for property-casualty insurance may render successful collusion difficult or even impossible.

B. Economic Indicators of the Likelihood of Collusion

1. Theory

Collusion can be difficult to detect: the conduct itself is usually covert, and the effects on prices can be difficult to discern, especially when competitive benchmarks for prices or output levels are not available. Economic theory, however, can help assess the likelihood of collusion from observable evidence on market structure.

In using evidence on market structure to evaluate the probability of collusion, correct market definition is crucial. Market definition involves identifying groups of products the sellers of which collectively would have market power in the sense that if they could coordinate their pricing decisions they would price significantly above competitive levels. ^{10/} Not all of these firms may currently be selling the same product in the same geographic area. However, any firm that is selling--or could readily sell--the same product, or other products that are good substitutes for the product in question, may undermine collusion, at least to some extent.

There are four aspects of market structure that are highly relevant to the probability that collusion will be attempted or will be successful if attempted. First, the fewer firms there are in a market, the easier it is for them to agree to raise price or restrict output and the greater the probability of collusion. Second, holding constant the number of firms, the greater the dispersion of market shares, the more likely it is that agreement among only a subgroup of the full number of firms would be necessary for collusion to be successful. Thus, a market with ten firms where two firms each hold forty-five percent of the market is more conducive to collusion than a market with ten equal-sized firms.

^{10/} See U.S. Department of Justice, Merger Guidelines (1984).

Third, the easier it is for colluding firms to detect and police any cheating on the collusive agreement by other cartel members, the greater the probability of collusion. In the insurance industry, for example, where the McCarran-Ferguson Act and state regulation often permit collective (i.e., bureau) rate making, colluding firms might find it easy to monitor each other's activities. This could facilitate successful collusion among insurers. On the other hand, in industries such as insurance, where the product is heterogeneous and multi-dimensional, individual firms can often increase quality in a continuous and subtle fashion, making cheating on a collusive agreement relatively difficult to detect and collusion less likely.

Finally, the entry of new firms into the market may limit or even completely deter collusion. ^{11/} Collusion would be deterred either if entry were so rapid as to make a price increase impossible, ^{12/} or if entry would eventually restore prices to their original or lower levels but leave the colluding firms with lower market shares so that long-term losses from collusion would outweigh any short-term gains. Furthermore, even if collusion would be profitable, rapid entry would shorten any collusive episode and reduce the probability of its recurrence.

2. Market Definition and Market Structure in the Property-Casualty Insurance Industry

In assessing collusion as a possible cause of affordability-availability problems in the crisis lines, it is first necessary to delineate the relevant markets. Under

^{11/} As noted above, it is appropriate to designate specific firms that readily could, but do not currently, sell the product in question as being "in the market" rather than "potential entrants." The difference between firms who do not currently sell a product being "in the market" and being "potential entrants" is mostly a question of time. According to the Department of Justice Merger Guidelines, if a firm could begin selling the product within one year, it is considered to be already in the market. If the firm would need more than one year, but less than two, it is considered a potential entrant.

^{12/} Under some circumstances, entry may make price increases not only unprofitable but impossible. For a discussion of such "contestable" markets, see Baumol, Panzer, and Willig (1982). But see Schwartz (1986).

principles outlined in the Department's Merger Guidelines, markets for purposes of competitive analysis are delineated by considering very narrow groups of products and expanding until a hypothetical monopolist of that group of products would have significant market power, i.e., the ability profitably to raise price. The analysis basically consists of assessing the extent to which a price increase for the product under consideration would cause a reduction in quantity that would be large enough to make the price increase unprofitable. In the case of insurance, a price increase could cause a quantity reduction either because of substitution to other types of insurance or because of substitution of self-insurance. The former type of substitution is not very likely: a doctor seeking malpractice insurance, for example, is unlikely to find fire insurance to be an acceptable substitute.

Self-insurance is likely to be the best substitute for any particular line of insurance. Self-insurance, however, is likely to be an unattractive alternative for the vast majority of individuals for most perils. The loss of one's home from fire or one's life savings from a malpractice suit, for example, both likely would be too devastating an event for one to be willing to risk. For such individuals, the only alternative to accepting a collusive price increase may be to form a mutual, where the policyholders share responsibility for the residual risk of the group by setting premiums ex post rather than ex ante. ^{13/}

Self-insurance is much more attractive for large corporations and governments. For governments, the residual risk can be spread across the taxpayers in that governmental unit. The larger the unit, the lower the cost of self-insurance, since, as long as all the risks assumed are not perfectly correlated, the larger the unit the less the residual risk assumed by each individual taxpayer and the easier it is for the individual taxpayer to pool that risk with other imperfectly correlated risks. For corporations whose equity holders can diversify widely and inexpensively in stock and

^{13/} The Risk Retention Act Amendments of 1986, Pub.L. No. 99-563, were designed to allow related or similarly situated businesses and groups to purchase their liability insurance on a group basis or to provide security in lieu of insurance through interstate cooperatives called risk retention groups.

other capital markets, the attraction of self-insurance is even greater. 14/

Notwithstanding any potential ability of large corporations and governments to self-insure in response to even a small collusive price increase, it is clear that a hypothetical monopoly supplier of any particular line of insurance would price well above competitive levels because of the unattractiveness of self-insurance to individuals and smaller corporations or governments. A hypothetical insurance monopoly likely would be able to raise price just to individuals if necessary, so large corporations and governments would not prevent the exercise of market power. 15/

14/ Indeed, one might ask why corporations would ever buy insurance. To the extent that the risks assumed by a corporation are ultimately assumed by shareholders who are capable of diversifying their portfolios directly, managers would appear to maximize share values by maximizing the expected value of earnings. Since the purchase of market insurance will always require payment of a premium over the expected cost, self-insurance would appear to always dominate. Paying such a premium may be in the interest of shareholders, however, if insurance reduces managerial control problems by allowing more concentrated equity ownership, or if insurance provides an outside check on opportunistic behavior by managers toward shareholders or by shareholders toward bondholders. In addition, especially if bankruptcy is possible, some insurable risks may ultimately be borne by non-shareholders such as workers or managers, who cannot inexpensively diversify away such risks. If the price such input suppliers would charge to assume those risks is greater than the premium over the expected cost that must be paid to an insurance company, the purchase of market insurance can be consistent with maximizing share values. Finally, if costs would be involuntarily borne by third-parties, federal or state laws are likely to require firms or individuals to buy insurance.

15/ If a sufficient number of large corporations and governments would self-insure in response to even a small collusive price increase, however, we would expect that an exercise of market power by insurers would not lead to a significant increase in all premiums, but rather to an increase in the premiums paid by individuals and small corporations and governments relative to those paid by large corporations and governments.

The next step in the analysis of market structure is to identify the competitors in the relevant markets. All property-casualty insurers in the United States should be considered as competitors in any relevant market if all easily could offer any particular line of insurance. To determine whether such is the case, the Division conducted telephone interviews with executives from a size-stratified sample of ten national and regional insurance companies, as well as with the insurance regulators of the ten most populous states plus West Virginia. The Division found strong indications that insurers normally can, quickly and easily, acquire the necessary licenses and expertise to either begin selling their existing lines of insurance in new states or to provide new lines in the states in which they are already licensed. This appears true even with respect to those lines considered in crisis. These facts suggest that, even though at any one time only a small number of firms may be observed writing a specific line in a particular state, all firms in the property-casualty industry in the United States should be included in the relevant market for any particular type of property-casualty insurance. 16/

The third step in the analysis of market structure is the assignment of market shares. Market shares should be assigned to competitors according to their abilities to compete and, in particular, to undermine any anticompetitive activities of rivals. The ability of an insurance company to expand output is potentially limited, at least in the short run, by state solvency regulation, which is keyed to certain financial ratios. Thus, these financial ratios could be combined with data on net assets to provide a capacity-based measure of market share. Data on premiums is more readily available, however, and, to the extent that premium-to-surplus ratios are uniform across firms, provide a good proxy for relative ability to write insurance. Thus, premiums were used to measure market shares. To the extent that insurers can shift capacity across types of insurance total premiums for all insurance would be the best measure. To be conservative, however, the premiums used were limited to the property-casualty lines.

16/ Companies that currently provide only life insurance but that could be expected to establish a property-casualty subsidiary in response to a collusive price increase could also be included in the property-casualty market.

C. Could Collusion Be the Cause of the Crisis?

Table I provides measures of market concentration for property-casualty insurance. The first line shows the Herfindahl-Hirschman Index, or HHI, ^{17/} for All Property-Casualty insurance in the United States from 1979 to 1985. Table I also shows the HHIs for Medical Malpractice and Other Liability insurance, lines that are generally considered to be in crisis. Even if these lines were appropriate markets and competitors limited to current sellers of these lines, the low HHIs would imply that collusion would be an unlikely explanation for significant increases in prices.

The highest HHI for All Property-Casualty was 229 in 1985. Even if Medical Malpractice and Other Liability were valid antitrust markets and competitors limited to just current sellers of those lines, their highest HHIs would be 663 and 278. These are low HHI values. The 1984 Department of Justice Merger Guidelines, for example, indicate that mergers raising the HHI to a level under 1000 are not a cause of competitive concern. These low levels of market concentration imply that successful collusion among property-casualty insurers is highly unlikely, even in the absence of any legal prohibitions.

Finally, even if collusion were likely in this unconcentrated market because of McCarran-Ferguson or state action immunity, there are several reasons why the current availability-affordability problems cannot be blamed on collusion. First, the antitrust immunities have applied to all lines of insurance since at least 1945, with de facto immunity since the 1869 decision of the Supreme Court in Paul v. Virginia, ^{18/} while the crisis is of relatively recent origin and is occurring in only a few lines. Second, collusion cannot explain unavailability: Firms do not collusively raise prices above costs and then refuse to sell the product. Third, collusion as an explanation for the large price increases .

^{17/} The HHI is an index of market concentration calculated by summing the squares of the market shares of all of the firms in the market. It varies from near 0 (extremely unconcentrated) to 10,000 (total monopoly). The HHI is higher, the smaller the number of firms and the more unequal their market shares. The HHI thus provides a single summary measure for the first two of the four aspects of market structure discussed above.

^{18/} 75 U.S. (8 Wall.) 168 (1869).

observed in recent years is directly contradicted empirically by both the fall observed over that period in the ratio of premiums to underwriting costs (discussed below in Section IV) and by indications of significant underperformance by property-casualty firms in recent years in the stock market (see Lacey (1976)).

All things considered, it is highly unlikely that increased collusion could have been a significant contributor to the recent affordability or availability problems in property-casualty insurance.

II. Imprudent Insurance Company Business Practices and Declining Investment Income

Some commentators cite short-sighted or otherwise imprudent business practices as possible causes of the crisis. In particular, they perceive the recent dramatic increases in premiums as a reaction by insurance companies to "inappropriate" (i.e., too low) pricing in previous periods. They further argue that declining investment income is a major cause of current affordability-availability problems.

It is maintained that during the late 1970s and early 1980s unusually high interest rates encouraged property-casualty insurers to lower their premium rates substantially. Because high returns on investments could be expected to offset anticipated casualty losses, insurers charged "artificially" low prices to attract business. As long as interest rates remained high, insurance companies could cover casualty losses while maintaining relatively low premiums.

The lower initial premiums could be made up by the higher investment income that could be earned on those premiums between the time they were collected and when they would be required to pay policyholders for their covered losses. Insurers were able--and, in a competitive market, would be forced--to lower their rates. In this scenario, falling interest rates in 1985 and 1986 resulted in an unanticipated decline in investment income. Insurers facing large anticipated casualty losses found themselves with investment income insufficient to cover those losses, and were forced to turn to their only remaining source of funds--current policyholders--whose premiums escalated rapidly. In sum, it is theorized that the additional income from recent, very substantial premium increases has been sought by insurers to compensate for unexpected declines in investment income.

Theoretical analysis suggests that if property-casualty insurance markets are competitive--and the concentration data presented above support that assumption--it would not be possible for insurers to recover sunk losses due to past pricing mistakes by charging higher, supra-competitive premiums to current policyholders, especially if new insurers, not suffering from previous errors, could profitably undercut the inflated premiums of the old insurers. 19/ Moreover, even if dramatic declines in investment returns could in theory have resulted in the observed availability and affordability problems, it is not clear that any such losses or declines have actually occurred. In particular, column 2 of Table 2 shows that net investment income as a percentage of premiums earned in the property-casualty industry increased significantly after 1980, from 7.88 percent of earned premiums over the 1967-80 period to 14.62 percent of earned premiums over the 1981-85 period. 20/ Thus, we must look to the property-casualty industry's underwriting gain/loss experience, shown in column 1 of Table 2, rather than to the industry's past investment experience, in order to explain either any financial problems in the industry or their actions on pricing and availability.

Regardless of past experiences, any decline in anticipated future investment returns would place upward pressure on overall premiums. But cyclical movements in anticipated investment income would not cause severe affordability-availability problems to appear suddenly in only certain lines. While some small part of the higher cost of property-casualty insurance today may be due to anticipations

19/ As noted in Section IV, below, however, unanticipated changes in the manner in which tort liability has been established and damages assessed can lead to large ex post losses on policies, especially (see Table 6) in lines where there are long delays between the time that premiums are set and received and the time that claims are settled. Unless new capital can flow easily into the industry, such accumulated losses may deplete reserves and, in the presence of solvency regulation or other constraints on the ratio of premiums to reserves, contribute to a supply problem, at least in the short run.

20/ As shown in Table 2, this increase of 6.74 percent is statistically highly significant. With an F-statistic of 66.10, the probability of such an increase being due to random movements is less than .01.

of lower investment income, the primary causes of the "crisis" must be found elsewhere. 21/

III. State Insurance Regulation

We turn now to the third potential cause of the insurance crisis, changes in state regulation. Any full discussion of state regulation of the insurance industry would be far beyond the scope of this report, but we can at least briefly examine three types of state regulation--regulation of prices, regulation of quality (i.e., solvency), and regulations that attempt to redistribute wealth by widening risk pools--and their potential roles in the crisis in property-casualty insurance.

Turning first to the potential role of price regulation, any regulatory change could result in both higher prices and unavailability if the regulators imposed regulations that raised costs or restricted output considerably and then allowed prices to rise by less than would have been required to clear the market. Alternatively, suppose that costs were rising--perhaps but not necessarily because of increased regulation--and the regulators responded by imposing price ceilings to limit the price increase. The result would be both higher prices and an availability problem, i.e., even at the higher prices, insurers would not be willing to supply as much insurance as consumers would like to buy.

There has been considerable research on the effects of regulation on the price of property-casualty insurance. Unfortunately, no consensus has emerged: some researchers have found that regulation has raised prices; others have found no effect. For example, Joskow (1973) found that prices for property-casualty insurance were higher in New York, where

21/ Even if anticipated net investment income were to fall to zero, however, the compensating proportional increase in premiums would not be greater than the previous ratio of anticipated net investment income to premiums. As shown in Table 4, the ratio of net investment to income has been highest in the crisis lines of Medical Malpractice and Other Liability, where, as shown in Table 6, the time between when premiums are collected and when losses are paid out is the greatest. The premium increases observed in these lines, however, have been far greater than these net investment ratios.

their attempts to set maximum prices are likely to be frustrated by reductions in quality. Under such conditions, the effect of maximum price ceilings is more likely to be unavailability of quality than unavailability of quantity.

Some industry observers have argued that such binding price ceilings did exist, at least through 1985, in those states where availability problems were particularly severe. The Antitrust Division's ongoing interviews with state regulators and insurance company executives, however, have not found any supporting evidence to date for this claim in the lines and states of the crisis. Moreover, in some lines, such as environmental exposure, unavailability appears to be a national problem and thus cannot be explained by state-specific events. Thus, some if not all of the explanations for unavailability must be found elsewhere than in state regulation.

The next major type of state regulation that needs to be considered is regulation of quality. Although the competitive nature of the insurance industry precludes the need for any form of price regulation, solvency regulation may be defended as one way to protect the interests of policyholders and third-party liability claimants, as well as other insurance firms that contribute to guaranty funds. Every state has a guaranty fund for its property-casualty insurers. If an insurer licensed to do business in a particular state goes bankrupt, the other licensed insurance companies in the state assume at least partial responsibility for the failed firm's policies through the guaranty fund. The inability to ex ante "experience rate" individual insurance companies' contributions to the guaranty fund creates an incentive for insurers to underwrite too many policies relative to their net assets. 22/

22/ The problem is analytically very similar to that created by the existence of federal deposit insurance that is available to all depository institutions. Financing such insurance with a flat-rate premium encourages depository institutions to assume more risk than if premiums were adjusted to reflect the risk of each bank's activities and investments. It can be argued that the appropriate response to potential moral hazard problems, whether in banking, insurance, or elsewhere, is to impose risk-based premiums. To the extent that risk-based premiums cannot be used, however, perhaps because of difficulties in accurately predicting the probability of bankruptcy, direct control measures such as minimum capital and surplus requirements or constraints on portfolio choice may be appropriate second-best solutions.

This type of market failure, however, cannot be used to

Footnote Continued

While solvency regulation can thus be defended in principle as a way to prevent insurers from free riding on each other, the efficiency or effectiveness of such regulation in practice is an empirical question (see Munch and Smallwood (1980)). Moreover, as noted in the next section, state solvency regulations may have played a significant role in the crisis due to their interaction with the increased uncertainty induced by changes in tort liability.

Finally, we turn to a third type of state regulation, restrictions on the size of risk pools. In several states, regulators have frustrated efforts by insurance companies to keep risk pools as narrow as possible in order to minimize the self-selection problem that is endemic to all insurance. Mandating broader, more heterogeneous risk pools can transfer wealth from low-risk to high-risk individuals, but only at a real cost. Broader risk pools reduce the efficiency of the insurance contract by increasing the real cost of insurance to low-risk consumers and thus reducing their demand. As enough low-risk consumers reduce the amount of insurance they purchase or even drop out of the pool entirely, insurance, like solid-gold Cadillacs, can become economically unavailable. ^{23/}

Without seeking to minimize the real costs of this type of regulation, however, it is difficult to identify regulatory broadening of risk pools as a major contributor to the current crisis. These regulations may well have contributed significantly to a long-term upward trend in insurance costs in a number of lines in particular states, but such increases do not appear to match the lines and states in crisis.

22/ Footnote Continued

justify regulations that maintain prices above competitive levels. There is a clear analogy here to the airline industry, where the recognition that price regulation was unnecessary and harmful to consumers led eventually to the dismantling of the CAB. In contrast, safety regulation by the FAA can still be justified since, because of limited liability, an airline with assets that were less than the maximum potential liability from a crash, including punitive damages, (literally a "fly-by-night" airline) would have an economic incentive to provide less than the optimal amount of safety.

23/ See Joskow (1973) and Priest (1986).

Finally, for all three types of state regulation, while significant research on their effects in the specific crisis lines is lacking, timing alone suggests the lack of a significant, or at least exclusive, connection. In the mid 1970s there was a crisis in medical malpractice insurance (see Freedman (1986)). The 1980s brought another crisis in Medical Malpractice, as well as in several other lines of property-casualty insurance. If regulation were to blame for these crises, one would expect to find that regulation increased during or slightly before each crisis and slackened at other times. This, however, does not appear to have been the case. The lack of any apparent correlation between changes in regulation and the development or resolution of availability-affordability problems in particular states indicates that state regulation is not directly to blame for the current crisis.

IV. Change and Uncertainty in Tort Liability

Perhaps the most frequently offered explanation for the current crisis in property-casualty insurance involves the legal system. Significant changes in the manner in which tort liability is established and damages are assessed are cited as causes of dramatic rate increases and reductions in insurance availability. Examples of these changes include the perceived movement from a fault-based standard to a no-fault standard, eased requirements for establishing joint and several liability, the award of very large damages for such noneconomic losses as pain and suffering, punitive or exemplary damages against insuring companies for bad-faith failure to acknowledge liability, and the shift from first-party to third-party tort insurance. 24/

In the rest of this section, we attempt to evaluate this explanation by examining the consistency of its implications with the available accounting data on changes over time in the

24/ See U.S. Department of Justice (1986). For an extensive and insightful analysis of the effects of shifting from first-party insurance to third-party corporate-provided insurance administered through the tort system, see Priest (1986). For a comparative analysis of the Canadian liability insurance crisis, which in many ways parallels the U.S. experience, see Trebilcock (1987) who concludes that the Canadian crisis was caused by increased uncertainty in the judicial determination of liability and quantification of damages.

costs and revenues of the property-casualty industry. 25/ We begin with broad overall data categories and progress to specific lines and narrower categories of costs and revenues, looking first for changes in average levels and then for signs of increased uncertainty.

A. Changes in Average Levels

The first implication of an explanation based on changes in the tort liability system is that we should observe a deterioration in the overall financial performance of the property-casualty industry, with the greatest deterioration occurring in the crisis lines. As can be seen from column 3 of Table 2, for all property-casualty lines combined there has been a significant decline in combined net income (the sum of underwriting gains and net investment income) as a percentage of premiums earned, from 6.18 percent over the 1967-80 period to 1.33 percent over the 1981-85 period. 26/

This deterioration in overall financial performance can also be seen in the last column of Table 4, which compares the 1976-80 period with the 1981-85 period for all property-casualty lines combined as well as for two crisis lines, Other Liability and Medical Malpractice, and two non-crisis lines, Private Passenger Auto Liability and Homeowners' Multiple Peril. For all lines of property-casualty, the overall operating ratio 27/ suffered a statistically highly significant deterioration of 8.64 percentage points, from 94.18 to 102.82. This deterioration is particularly marked in the crisis lines. In the two non-crisis lines, Auto Liability and Homeowners, overall operating ratios rose respectively by 9.42 points to

25/ We should stress that empirical testing can only disprove hypotheses: If the implications of a particular hypothesis are inconsistent with the data, the hypothesis can be rejected, but since any given set of data may be consistent with the implications of a number of hypothesis, a particular hypothesis can never be empirically proven.

26/ The F-statistic for a test of equality of means is 5.55, implying that the probability of this decline being due to random variations is less than .01.

27/ The overall operating ratio is the ratio of total expenses (i.e., losses incurred plus loss adjustment expenses plus commissions and brokerage expenses plus other underwriting expenses plus dividends) minus net investment gain and other income, to premiums earned.

101.24 and by 6.88 points to 103.96. Both the increases and the final levels are considerably greater, however, in the two crisis lines, Other Liability and Medical Malpractice, where overall operating ratios rose respectively by 22.86 points to 113.52 and by 21.96 points to 113.58.

A second implication of an explanation based on changes in the tort liability system is that this deterioration in overall financial performance should be due to declines in underwriting gains (or increases in underwriting losses) rather than declines in net investment income. As discussed in Section II, this implication is strongly supported by the data in Table 2, which shows a statistically highly significant increase in net investment income as a percent of earned premiums, from 7.88 percent over the 1967-80 period to 14.62 percent over the 1981-85 period, combined with a statistically highly significant increase in underwriting losses as a percentage of earned premiums, from 1.70 percent for 1967-80 to 13.28 percent for 1981-85.

Continuing this disaggregation process, Table 3 shows that, for all lines of property-casualty insurance, this deterioration in the ratio of underwriting costs to premiums earned, by 11.64 percentage points, from 100.74 over the 1961-80 period to 112.38 for the 1981-85 period (as shown in the last column of Table 3) cannot be explained by increased administrative expenses, which actually fell somewhat as a percentage of premiums written. The source instead lies entirely with the increase in the ratio of underwriting losses and adjustment expenses to earned premiums by 12.56 percentage points, from 70.44 percent to 83.00 percent. This result is confirmed in Table 4. For all lines of property-casualty, the underwriting losses incurred (the first column of Table 4) increased significantly by 8.60 points and by 1.56 points, respectively in both the non-crisis lines, Homeowners and Auto Liability. In the crisis lines of Other Liability and Medical Malpractice, however, the increases in the underwriting loss ratio and the loss adjustment ratio have been much more dramatic: 21.74 percentage points and 9.70 percentage points for Other Liability, and 35.50 percentage points and 6.46 percentage points for Medical Malpractice.

The determination that the source of the deterioration in the overall financial ratios for the property-casualty industry lies entirely in increases in underwriting losses and adjustment expenses, with particularly dramatic increases observed in the crisis lines, is consistent with the implications of a hypothesis that the crisis is due to changes in the tort liability system. By contrast, the data appear to

directly contradict the implications of two other hypothesized potential causes of contributions to the crisis, collusion and declines in investment income. The collusion scenario would imply an increase in the ratio of premiums to underwriting costs rather than the statistically highly significant decrease actually observed, while the investment scenario would imply a decrease in the ratio of net investment income to premiums, rather than the statistically highly significant increase actually observed.

B. Increased Uncertainty

If insurers were risk-neutral, the competitive premium for a policy would be the expected value of its cost. Bankruptcy costs and insurance regulations, however, require insurers to maintain minimum solvency levels in order to limit the probability of default. This requires insurers to load (raise) premiums by a factor over actuarially fair premiums in order to ensure a sufficiently low probability of failure. This load factor is higher, the greater the uncertainty with respect to the insurer's future net income. Thus, a costly change in the legal environment that also increased the variability in the financial results would induce a premium increase greater than the increase in the expected value of costs. 28/

An increase in variability of casualty losses and investment income thus could trigger a crisis because insurers would have to set higher premiums in order to maintain an acceptable fixed probability of financial solvency. If the increase in financial variability becomes sufficiently large, the premiums required to maintain solvency requirements might be so high that coverage would be unattractive to or even out of the reach of potential insureds. There would then appear to be an affordability crisis in the affected line. Should variability be so great as to exceed the ability or willingness of insurers to cope with it, coverage might be unavailable at any price. Questions would remain as to the underlying causes of large, perhaps greatly increased, variability, but an adverse effect on the affordability of insurance is predictable whatever those causes actually are.

To track down the source of any potential increase in uncertainty, we carry out the same disaggregation process as in

28/ For a more rigorous mathematical modeling of the effects of uncertainty on load premiums, see Clarke, Simon, Smith, and Warren-Boulton (1986) and Winter (1986).

the examination of changes in the average level of financial ratios. We measure the variability of each ratio by its standard deviation. Normalized comparisons of variability across ratios of different mean values can be made by computing each ratio's coefficient of variation, i.e., the standard deviation of the ratio divided by its mean. 29/

Table 2 shows that while the standard deviation (variability) of the underwriting gain/loss ratio has risen significantly during the 1980s relative to the 1967-80 period, the standard deviation of the net investment income ratio has actually declined significantly. This greater variability of the underwriting gain/loss ratio becomes clear when we note that the coefficient of variation for the underwriting gain/loss during 1981-85 was .41--ten times the coefficient of variation for net investment income, which measured only .04 over the same period. This suggests that any increase in overall uncertainty must have resulted from increased unpredictability of loss payouts and expenses rather than from any increase in the instability of investment income. Combined with the observation from Tables 2 and 4 that investment income increased significantly after 1980, this would appear to make it very difficult to blame imprudent investments for causing today's premium hikes and coverage withdrawals.

Table 3 shows that the variability of both the administrative expense ratio and the dividend ratio has actually decreased, though insignificantly. This result narrows the source of any increase in uncertainty even further, to the underwriting loss and adjustment ratio.

29/ The relevant definition of uncertainty is uncertainty in the prediction of ratios over the life of policies currently being issued. To the extent that these ratios are serially correlated, however, i.e., to the extent that they follow a predictable cycle or trend, the standard deviation will overestimate the absolute level of uncertainty. Under such conditions, a more accurate measure would be the standard error of a predictive equation for the ratios over time. Even if the assumption of serial independence is unwarranted, however, if the degree of serial correlation is held constant, changes in the standard deviation provides an unbiased measure of changes over time in the degree of uncertainty.

More accurate measures of uncertainty may be developed in the near future. In addition to improving indexes for uncertainty that are based on accounting data, efforts are being made to develop ex ante measures of uncertainty using data from financial and capital markets.

The pattern of increased uncertainty emerges most clearly in Table 4. While the increase in the variance of the overall operating ratio was not statistically significant for All Lines of property-casualty combined, variability in the loss incurred and loss adjustment ratios increased significantly. The two non-crisis lines showed no significant increases in variability in either their overall operating ratios or any of the component ratios. Furthermore, of the crisis lines, only Other Liability exhibited a substantial increase in overall variability as well as substantial increases in the variability of underwriting losses.

This suggests an anomaly. Why does the other crisis line, Medical Malpractice, fail to exhibit such increases in variability of its ratios? There is an explanation. Medical Malpractice is a line of insurance that has popularly been thought to have been in a state of crisis since the mid-1970s. Thus, it is not anomalous that its variability has not increased greatly over the 1980s--it was highly variable to begin with. To see this, one need only look at the coefficient of variation exhibited by Medical Malpractice's overall operating ratio in 1976-80 and in 1981-85 as shown in Table 5. In both the earlier and later periods it was .09. Compare this with the coefficients of variation in the overall operating ratio for Other Liability. In the earlier period its coefficient of variation was only .05, but it soared to .11 in the later period.

In fact, if one examines the levels of all lines' coefficients of variation in the period 1981-85, one sees that these coefficients of variation are almost universally higher for each ratio in the crisis lines than for the corresponding ratio in the non-crisis lines.

Table 5 thus shows a sharp distinction between the crisis and non-crisis lines in terms of the variability of their financial ratios. As noted above, increasing variability reflects the increasing difficulty for insurers in accurately predicting their future liability, and therefore in their ability to underwrite the risks. To maintain an acceptable probability of solvency, insurers may choose either to raise premiums to "safe" levels, or to withdraw coverage from these lines.

One source of the greater financial uncertainty observed in the crisis lines may be the greater severity of delays before final settlement in the crisis lines. As shown in Table 6, for All Lines of property-casualty insurance, 18.30 percent of

claims incurred in 1982, for example, were unpaid at the end of 1985. For Other Liability, however, 44.79 percent of expenses incurred in 1982 were unpaid at the end of 1985 while for Medical Malpractice 64.42 percent of expenses incurred in 1982 were unpaid at the end of 1985. Such delays suggest a more uncertain and thus more costly tort liability process.

The overall pattern in the data is thus one of high and increasing cost ratios for underwriting losses and adjustment expenses, especially in the crisis lines, and high and increased variability in these ratios for the crisis lines. These changes can cause dramatic increases in premium rates. Because of the increased load factors required by increased uncertainty, premium increase can be expected to be significantly greater than even the already large increase in costs in those lines. Increased cost ratios and uncertainty in crisis lines also can give rise to unavailability problems in those lines. Thus, given the findings from several studies that changes in the tort liability system have caused both higher expected awards and greater variability in such awards, the overall pattern of the data is consistent with explanations for the property-casualty crisis grounded in these changes in the tort liability system.

Table 1

National Herfindahl-Hirschman Indices for
Select Insurance Lines, 1980-1985

	1980	1981	1982	1983	1984	1985
All Property- Casualty	213	213	215	225	226	229
Medical Malpractice	513	523	500	567	663	622
Other Liability	224	219	220	220	236	278

SOURCE: A.M. Best's Aggregates and Averages (1980-1986).

Table 2

Time Series Variation in Property-Casualty Industry Operating Results

Years	Underwriting Gain/Loss (Percent to Earned Premiums)		Net Investment Income (Percent to Earned Premiums)		Combined Net Income (Percent to Earned Premiums)	
	yearly avg.	std. dev.	yearly avg.	std. dev.	yearly avg.	std. dev.
1967 - 1980	-1.70	3.35	7.88	1.78	6.18	3.99
1981 - 1985	<u>-13.28</u>	<u>5.41</u>	<u>14.62</u>	<u>.65</u>	<u>1.33</u>	<u>4.93</u>
Change	-11.58	2.06	6.74	-1.13	-4.85	.34
F statistic for equality of means or increase in variance	31.98***	2.61*	66.10***	7.70*** ¹	5.55**	1.89

***Significant at .01 level

**Significant at .05 level

*Significant at .10 level

¹F statistic of decrease in variance.

SOURCE: Best's Aggregates and Averages: Property and Casualty 1986, p. 72

Table 3

Time Series Variation in Property-Casualty Industry Loss and Expense Ratios

Years	Loss and Adjustment Ratio to <u>Premiums Earned</u>		Administrative Expenses Ratio to <u>Premiums Written</u>		Premium Dividend Ratio to <u>Premiums Earned</u>		Combined Ratio to <u>Premiums Earned</u>	
	yearly avg.	std. dev.	yearly avg.	std. dev.	yearly avg.	std. dev.	yearly avg.	std. dev.
1961 - 1980	70.44	3.78	28.54	2.26	1.76	.29	100.74	3.01
1981 - 1985	<u>83.00</u>	<u>5.25</u>	<u>27.50</u>	<u>.26</u>	<u>1.86</u>	<u>.18</u>	<u>112.38</u>	<u>4.82</u>
Change	12.56	1.47	-1.04	-1.30	.10	-.11	11.64	1.88
F statistic for equality of means or increase in variance	39.10***	1.93	1.03	.18	.61	.39	47.79***	2.64*

***Significant at .01 level

**Significant at .05 level

*Significant at .10 level

SOURCE: Best's Aggregates and Averages: Property-Casualty, 1986, p. 75

Table 4

Time Series Variation in Underwriting Experience - By Line

Line	Years	Losses Incurred ¹		Loss Adjustment Exp. ¹		Commission & Broker Exp. ²		Other Underwriting ²		Dividends to Policy ¹		Net Investment Gain/Loss & Other Income ¹		Overall Operating Ratio ¹	
		avg.	std. dev.	avg.	std. dev.	avg.	std. dev.	avg.	std. dev.	avg.	std. dev.	avg.	std. dev.	avg.	std. dev.
Total All Lines	'76-'80	63.60	2.20	9.24	.21	12.94	.21	12.96	.55	1.42	.26	5.96	.92	94.18	2.45
	'81-'85	<u>72.20</u>	<u>4.64</u>	<u>10.80</u>	<u>.65</u>	<u>12.52</u>	<u>.29</u>	<u>14.98</u>	<u>.70</u>	<u>1.86</u>	<u>.18</u>	<u>9.56</u>	<u>.84</u>	<u>102.82</u>	<u>4.06</u>
Change		8.60	2.44	1.56	.44	-.42	.08	2.02	.15	.44	-.08	3.60	-.08	8.64	1.61
	F	14.00***	4.46*	26.00***	9.88**	6.78**	2.02	25.66***	1.62	9.68**	.49	41.51***	.84	16.57***	2.75
Homeowners'	'76-'80	58.48	5.37	7.00	.37	18.56	.36	12.86	.15	.64	.13	3.16	.29	94.36	5.21
	'81-'85	<u>65.66</u>	<u>3.02</u>	<u>8.18</u>	<u>.46</u>	<u>17.42</u>	<u>.12</u>	<u>13.86</u>	<u>.34</u>	<u>.06</u>	<u>.01</u>	<u>4.46</u>	<u>.42</u>	<u>101.24</u>	<u>3.26</u>
Change		7.18	-2.28	1.18	.29	-1.14	-.21	1.00	.19	-.58	-.12	1.30	.20	6.88	-1.95
	F	6.72**	.33	12.17***	3.09	41.92***	.17	35.46***	5.13*	.29	.56	25.92***	2.92	6.25**	.39
Auto Liability	'76-'80	65.90	2.23	11.38	.34	10.42	.26	13.34	.28	.88	.37	6.32	.64	94.54	2.31
	'81-'85	<u>76.12</u>	<u>4.05</u>	<u>12.08</u>	<u>.43</u>	<u>9.92</u>	<u>.18</u>	<u>14.24</u>	<u>.26</u>	<u>.84</u>	<u>.15</u>	<u>9.20</u>	<u>.74</u>	<u>103.96</u>	<u>3.23</u>
Change		10.22	1.82	.70	.09	-.50	-.08	.90	-.02	-.04	-.22	2.88	.10	9.42	.92
	F	24.42***	3.30	8.06**	1.60	12.62***	.48	27.74**	.87	.05	.17	42.89***	1.35	22.42***	1.95
Other Liability	'76-'80	55.14	3.26	19.28	1.03	14.14	.29	12.86	1.38	.54	.09	11.32	2.04	90.66	4.25
	'81-'85	<u>76.88</u>	<u>12.52</u>	<u>28.98</u>	<u>3.87</u>	<u>12.38</u>	<u>.92</u>	<u>17.30</u>	<u>2.63</u>	<u>.64</u>	<u>.11</u>	<u>22.70</u>	<u>3.02</u>	<u>113.52</u>	<u>12.50</u>
Change		21.74	9.26	9.70	2.84	-1.76	.63	4.44	1.25	.10	.02	11.38	.98	22.86	8.25
	F	14.13***	14.77**	29.27***	14.06**	16.65***	10.20**	11.20**	3.64	2.38	1.63	48.86***	2.20	14.98***	8.64**
Medical															
Malpractice	'76-'80	68.70	10.42	26.56	2.74	6.22	1.06	7.72	.97	1.08	.80	18.66	7.34	91.62	8.53
	'81-'85	<u>104.20</u>	<u>9.36</u>	<u>33.02</u>	<u>3.70</u>	<u>4.98</u>	<u>.33</u>	<u>10.24</u>	<u>1.32</u>	<u>1.34</u>	<u>.29</u>	<u>40.18</u>	<u>3.27</u>	<u>113.58</u>	<u>10.73</u>
Change		35.50	-1.06	6.46	.96	-1.24	-.73	2.52	.35	.26	-.41	21.52	-4.07	21.96	2.20
	F	32.14***	.81	9.82**	1.82	6.54**	.05	11.78***	1.86	.43	.24	35.89***	.20	12.84***	1.58

*** Significant at .01 level

** Significant at .05 level

* Significant at .10 level

¹ Percent of premiums earned² Percent of premiums written

F statistics against null hypotheses of

- equal means

- increasing variance

Table 5

Coefficients of Variation in Underwriting Experience By Line

	<u>Losses Incurred</u>		<u>Loss Adj. Exp.</u>		<u>Comm. & Brok.</u>		<u>Other Underwriting</u>		<u>Dividends</u>		<u>Net Investments</u>		<u>Overall Operating</u>	
	1976-80	1981-85	1976-80	1981-85	1976-80	1981-85	1976-80	1981-85	1976-80	1981-85	1976-80	1981-85	1976-80	1981-85
Total All Lines	.03	.06	.02	.06	.02	.02	.04	.05	.18	.10	.15	.09	.03	.04
Homeowners'	.09	.05	.05	.08	.02	.01	.01	.02	.20	.17	.09	.11	.06	.03
Auto Liability	.03	.05	.03	.04	.02	.02	.02	.02	.42	.18	.10	.08	.02	.03
Other Liability	.06	.16	.05	.13	.02	.07	.12	.15	.17	.17	.18	.13	.05	.11
Medical Malpractice	.15	.09	.10	.11	.17	.05	.13	.13	.74	.29	.39	.08	.09	.09

SOURCE: Computed from Table 3. The coefficient of variation is: (standard deviation)/(average).

Table 6

Fraction of Total Losses and Loss Expenses that Remain Currently Unpaid

<u>Year When Loss Was Incurred</u>	<u>Total All Lines</u>	<u>Various Multiple Peril</u>	<u>Auto Liability</u>	<u>Other Liability</u>	<u>Medical Malpractice</u>
Prior to 1976	2.42	.55	.26	6.46	15.66
1976	5.05	.88	1.02	12.32	24.88
1977	5.45	1.20	1.34	13.34	27.62
1978	6.43	1.87	1.57	15.50	32.74
1979	7.75	2.26	2.21	19.78	39.21
1980	9.70	3.31	3.45	24.89	46.24
1981	13.40	5.74	6.19	33.80	54.52
1982	18.30	8.79	10.95	44.79	64.42
1983	26.42	13.54	19.77	59.92	76.57
1984	38.96	20.87	34.80	74.60	87.02
1985	65.69	44.26	65.68	90.80	96.98

SOURCE: Best's Aggregates and Averages: Property-Casualty, 1986, pp. 59-60

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January 26, 1989

James P. Lynn, Chairman
Aetna Life and Casualty Company
151 Farmington Avenue
Hartford, CT 06156

Dear Mr. Lynn:

I am writing to you about how Aetna can reduce costs -- especially through loss prevention -- instead of continuing its three decade drive to take away injured peoples' legal rights in courts of law.

Insurance companies say that Californians should be denied their right to receive Proposition 103's rate relief and insurance industry reform because, they say, Prop. 103 will cost them money. They say that the one-year 20 percent rate reduction ordered by Prop. 103 is unfair and unreasonable since auto insurance rates are already too low, and because "costs," i.e. legal fees, medical bills and car-repair expenses, are rising. "The cost increases have outpaced our ability to manage efficiently, so we have to charge more," Safeco's president told the Wall Street Journal.

Rather than looking at their own waste, inefficiency, mismanagement and inattention to loss prevention for the solution to controlling costs, insurers have spent many millions of dollars campaigning not only to defeat proposed reforms of the insurance industry, but to restrict the rights of victims to sue the perpetrators of their harm and obtain fair compensation for injuries.

Proposition 103's enactment, notwithstanding the industry's multi-million dollar campaign to defeat it, has mobilized citizens nationwide to fight for strengthened regulation and increased competition for the insurance industry. Therefore, companies will have to look for ways to reduce their costs, specifically through more efficient operation, and more effective advocacy for health and safety to prevent injuries and property damage from occurring.

1. Efficiency

The insurance industry represents one of the greatest bundles of capital ever brought together in world history. Property/casualty companies in the United States have assets totalling over \$300 billion; and over 2,000 life insurance companies have assets totalling over \$900 billion. This huge industry, however, is an inefficient and wasteful bureaucracy. If insurance companies operated more efficiently, they could easily reduce rates.

For example, in the private passenger automobile liability line, the industry overall pays 35.3 percent of what it writes in

41.5
Letter to James P. Lynn, Page 2.

loss adjustment and underwriting expenses, including claims processing, defense fees, commissions and brokers. Yet USAA, one of the best service companies in the market, operates at only a 20 percent expense level. According to the National Insurance Consumer Organization, auto liability insurance rates would drop by an average of 19 percent nationally if the industry on average were as efficient as USAA.

Insurance companies have operated so inefficiently in California and elsewhere because the insurance market is, in important ways, not competitive. Insurers engage in price-fixing because such practices are not subject to antitrust laws. In addition, states have anti-rebate laws which prohibit insurance agents from offering discounts to policyholders. As a result, the most efficient agent can not compete for market share by offering a discount. Also, many state laws prohibit group auto and homeowner insurance sales which could enhance buyer bargaining power. And consumers do not have access to good, comparative information about prices and services.

Proposition 103 repeals the antitrust exemption, the rebate and the group sales prohibition in California and allows banks to sell liability insurance. Prop. 103 also provides for a computerized consumer information system to facilitate comparison shopping. These measures should provide much needed incentive to insurers to reduce costs caused by waste and inefficiency.

In addition, insurers could be doing much more than simply complaining about legal, medical and auto repair expenses which they say are driving up their costs. For example, insurance companies often insist that information they provide plaintiffs during the discovery process in product liability cases be kept completely confidential. This not only keeps important safety information that can lead to hazard alerts and policies, from consumers and public agencies, but also it forces plaintiffs to start from scratch the discovery process in each similar case, driving up both plaintiff and defense legal fees.

As for medical costs, health insurers like Aetna could be aggressively pushing for strict guidelines to reduce physician's misuse of unnecessary medical tests, like chest X-rays and electrocardiograms, as well as unnecessary surgery, which add billions to health care costs in this country. Former HEW Secretary Joe Califano recently observed in the New York Times Magazine that Americans are four times more likely to have coronary bypass surgery than Western Europeans with the same symptoms, and that at least half of the 900,000 Caesarean sections performed in 1986 were unnecessary.

Insurance rates have risen out of all proportion to auto repair costs, according to the National Insurance Consumer Organization. Even so, however, insurers could be doing much more to encourage automobile design changes which would reduce repair costs without sacrificing safety, and reduce auto theft, which is responsible for the largest component of comprehensive insurance costs. I recently received a letter from a Houston inventor who has developed a patentable computer key system which

would make cars virtually impossible to "hot-wire" and steal. He contacted a number of insurance companies, as well as his local chapter of the industry-backed National Auto Theft Bureau, with his idea. Not a single insurer responded, and the NATB chapter provided him no encouragement or support.

2. Loss Prevention

Former Pennsylvania insurance commissioner Herbert Denenberg wrote in 1970,

It would be an act of gross social irresponsibility to permit insurance companies to acquire this expertise in saving life and limb and then permit them to utilize this information only for the purpose of estimating the cost of deaths and injury and not for the purpose of eliminating death and injury.

The insurance industry should be the safety sentinel for the nation's economy. The industry should put into practice its theoretical vested interest in increasing profits by reducing claims and should be making great strides in areas of hazard control and loss prevention. Unfortunately, and contrary to their historic mission, however, insurers are barely lifting a finger to eliminate or reduce hazards that cost insurers billions yearly.

Three centuries ago, Lloyd's of London wrote insurance for ships travelling to the Orient on the condition that the insurer adopt certain safety precautions, such as equipping ships with lifeboats. That was an early display of the insurance industry's early commitment to loss prevention, and it had some notable successes in succeeding centuries, such as in the areas of industrial boiler and elevator safety.

But today, insurance companies are usually indifferent to loss prevention because they have become predominantly cash-flow financial institutions. More and more attention is paid to increasing investment income through premium volume. They pay very inadequate attention to safety and engineering contributions that could reduce premiums but retain prudent underwriting profits. Insurance companies would much rather charge a premium of \$1,000 and pay out \$500 in claims, then charge \$500 and pay \$250 in claims, because they would prefer having more money to put in investments that pursue their financial objectives.

As a result, even repeated litigation arising from well-known and identical hazardous products or services has not prompted the insurance industry to insist that hazards be eliminated. In the area of auto safety, the Insurance Institute for Highway Safety (IIHS), once an important voice in efforts to ensure crashworthiness and permanent design safety improvements to motor vehicles, has shifted focus in recent years from the automobile product to the automobile victim. While supporting seat-belt and drunk driving laws -- as do many other consumer and victim groups -- the IIHS recently has shown less public interest in crashworthiness issues. For example, although side impact

crashes result annually in nearly 3,000 deaths and 25,000 serious injuries, IIHS offered no position during NHTSA's 1986 hearings on side crashworthiness protection.

Unfortunately, IIHS has aligned itself with the automobile industry in other areas detrimental to the public health and safety. For example, IIHS supported Ford's petition to extend to 1994 full implementation of DOT's passive restraint rule, giving companies four more years to satisfy the requirement with driverside only air bags, instead of full front air bags or automatic belts. The Center for Auto Safety called Ford's petition an attempt to hold "the safety of the American driving public for ransom."

Insurance companies point to the IIHS and other safety and anti-crime organizations such as the Insurance Crime Prevention Institute and the National Auto Theft Bureau, as evidence of their financial commitment to safety organizations and loss prevention. Notice, however, the insurance industry's inattention in pressing automobile companies to design more theft-resistant locks, especially GM whose locks car thieves have long known are easier to defeat. And compare, for example, the \$7.6 million annual budget of the IIHS with the far greater resources needed to advocate, test and lobby for loss prevention in auto safety.

In addition, our 1987 survey of 11 major U.S. property/casualty company foundations showed that casualty prevention is not accorded much of a priority in making foundation grants and other contributions. Only Travelers contributed as much as \$10,000 to safety (meaning loss prevention) programs. Aetna, American Financial Corporation, Chubb, Continental and Farmers Insurance Group contributed \$5,000 or less. See "Loss Prevention and the Insurance Function," published in the Fall, 1987 Suffolk University Law Review.

Moreover, if insurance companies were sufficiently determined to minimize hazards causing injury and death, they could easily use their rate and coverage control to accomplish their goal. For example, companies could use their own rating function to penalize through increased rates insureds who do not improve safety, or require implementation of hazard prevention measures as part of the insurance contract. They could establish structured programs to disclose information about product hazards, which their investigators have documented for their insurance company files, to those authorities responsible for ensuring safety. (The media has learned to look infrequently to insurance companies for such information or comment.) And they could set more quickly and amply loss prevention examples in their own shop, such as by requiring their entire fleet of cars to be air bag equipped. Only a very few casualty companies have done the latter. The major life companies have not.

Moreover, insurers have innumerable opportunities to exercise their full muscle before government bodies, whether lobbying Congress, formally petitioning regulatory safety agencies, or seeking enforcement of health and safety standards

in judicial proceedings. Instead, the contact insurance companies have with the court system is in fighting claims and essentially defending hazards. A few luminous exceptions have occurred, such as when State Farm successfully petitioned the U.S. Court of Appeals to reverse NHTSA's 1981 rescission of the automatic restraint standards, or when State Farm and Allstate challenged the 2 1/2 mph bumper protection standard. But even the IIHS has only occasionally petitioned for auto recalls and even more rarely for new or stronger motor vehicle safety standards.

To demonstrate how little attention insurance companies pay to safety and loss prevention, consider the nationwide trend in motorcycle helmet use laws. Between 1966 and 1973, almost every state had passed a motorcycle helmet use law. But by 1980, 29 states had repealed or weakened their law and insurance companies did virtually nothing to stop them. More than 500 excess deaths and many more serious injuries occur yearly in those states with no, or weak helmet laws, compared to states with strong laws. A few other examples serve to demonstrate what opportunities insurance companies have to reduce claims and therefore costs by insisting on the reduction or elimination of hazards.

a. Vehicle Safety:

55 mph speed limit: In 1987, a closely divided U.S. Congress revoked the federal 55 mph speed limit on federal interstate highways, leaving to the states authority to raise the limit to 65 mph. According to NHTSA, in the 38 states that have upped the limit on rural roads in the past year, deaths on these highways have increased 19 percent -- an increase nearly three times as high as in states that kept the 55 mph limit.

The insurance industry must share the blame for the increasing costs resulting from this predictable increase in deaths and injuries. Although the IIHS and some companies devoted some support efforts to try to preserve the 55 mph speed limit, had the industry devoted its full political muscle to this issue, there is little doubt the industry could have prevailed on Congress to preserve this proven highway safety measure. And now that the grim facts about increased deaths and injuries are in, why are insurance companies not fighting to lower highway speeds at the state level, or to ensure the 55 mph speed limit is maintained in states which have not raised it?

Air bags: The air bag can save at least 12,000 lives and hundreds of thousands of serious injuries a year in this country. Some major auto insurers are providing some financial incentives to encourage purchases of cars equipped with air bags (although the IIHS says the major AAA and other motor club insurers provide no incentive unless required to do so by law as in New York state). The IIHS says USAA's incentive program is exceptional for providing unusually large discounts for medical and personal injury protection for cars equipped with air bags (60 percent,

where as most companies' discounts range from 20-30 percent for medical and personal injury protection). During 1988, USAA also provided \$300 to any policyholder who bought or leased a car equipped with an optional air bag (although for the bonus to apply, the air bag must have been optional, and even this bonus was discontinued in 1989).

But if all insurers put their muscle behind air bags by encouraging air bag retro-fitting, equipping their own entire company fleets with air bags as has Travelers Insurance Co., pushing for mandatory regulations for air bags or their equivalents, many more lives could be saved and billions of dollars more could be saved annually in health costs, wage loss and disability payments.

Seatbelts: The National Highway Transportation Safety Administration (NHTSA) conservatively estimated that in 1987, "the 25 percentage point rise in national belt use over 1984 levels saved about 1,300 lives and prevented about 16,000 moderate-to-serious injuries. The resultant reduction in automobile insurance claims was roughly \$1 billion to \$2.5 billion. Other public and private insurers probably saved another \$0.5 billion to \$1.25 billion."

But while seatbelt use in automobiles has reduced deaths, serious injuries and insurance costs, it is not used to reduce premiums. Also, these benefits have not been extended to workers who must drive dangerous vehicles on the job. For example, according to a 1987 Trial magazine article, at least 100 forklift operators are killed or seriously injured each year as they are thrown out, or jump out of forklifts that accidentally tip over. Many tests have demonstrated the effectiveness of seat belt use in preventing these injuries, and although a few companies like Clark Equipment Co. and U.S. Steel require that seat belts be installed on forklifts, most insurance companies have not insisted on this condition.

James W. Smirles, national broker liaison with the Long Grove, Ill.-based Kemper Group, told a risk managers' conference this year that in the worker compensation area, the difference between a very good and a very bad safety record can cause them to raise premiums as much as 400 percent. Wouldn't workers be better off if insurers simply insisted that for continued coverage, employers provide safety protections so that their workers are protected from such accidents so that injuries and insurance claims can be reduced?

5 mph bumper standard: Between 1978 and 1982, the government required a 5 mph bumper protection standard, which the Carter administration's Department of Transportation estimated would save consumers over \$400 million a year. Despite overwhelming consumer support for this standard, the Reagan administration, after heavy lobbying by General Motors, rolled the bumper protection standard back to 2 1/2 mph.

While fender-bender accidents represent a large segment of insurance company costs, insurance companies, with a few exceptions like Allstate and State Farm, paid very little attention to this development. In addition to applying its lobbying muscle in Congress, if not before the DOT to have prevented the rollback of bumper protection standards, insurers could have petitioned the government to reinstate the standard once data on the 2 1/2 mph standard's impact came in. They did not. Moreover, insurers have not insisted on bumper standards for light trucks and vans, which now comprise about 1/3 of all new vehicles sales.

b. Fire and Electrical Safety.

Deaths and injuries due to fire are largely preventable. In Japan, for example, the rate of fire deaths is half that of the United States -- 25.7 per million in the United States; 12.5 per million in Japan.

The insurance industry frequently points to its past help in originating the national electrical code and establishing Underwriters' Laboratories and the National Fire Protection Association as examples of its past commitment to loss prevention and fire safety. Yet these efforts are small compared to what the industry should be doing now to make these institutions real change-agents rather than indentured servants.

First, the industry-backed Underwriters' Laboratories' seal of approval on electrical devices does not always ensure the product's design safety. For example, after an alarming increase in residential fires due to kerosene heater use, UL recently upgraded its kerosene heater standard, UL 647, to help reduce some of the fire deaths and injuries. However, the compromise standard failed to address some problems, such as flare-ups and afterburn. See, for example, the analysis in the 1988 report by the Federal Emergency Management Agency/U.S. Fire Administration, "Alternative Heater Fires: A Critical Review of Safety Issues." Moreover, after UL 647 was upgraded, retailers were still permitted to sell out existing stocks of substandard heaters.

Similarly, in a November, 1987, New York Times column, the president of a mailorder home appliance company expressed outrage that UL's new standard to prevent electrocution from accidental immersion of hair dryers in water, applied only to hair dryers manufactured after October 1, 1987. Retailers were permitted to sell out their stock of substandard hair dryers. As a result, during the 1987 Christmas buying season, new and old dryers were on the shelves, both with UL labels, and consumers could not tell which were substandard.

Moreover, insurance companies have not actively promoted the fire-safe cigarette, nor advocated strongly for residential sprinklers. They recently have pushed for tougher criminal laws for arsonists, and have assisted efforts to help catch arsonists with the Insurance Committee for Arson Control and the Insurance Crime Prevention Institute. But David Hemenway, an economist at

the Harvard School of Public Health and a Pew Fellow in Injury Control who has studied insurance industry efforts to promote residential fire safety, has written that the size of these efforts is minuscule compared to the size of the insurance industry and the magnitude of the fire problem. This is an important observation. The insurance industry, when it goes beyond mere rhetoric, rarely puts more than a tiny fraction of its resources and power beyond public and private safety, health and property damage prevention efforts. But Aetna and other companies are known to lobby very vigorously against victims' rights or repeal of the McCarran-Ferguson Act.

Insurers have released very little useful statistical fire data to those responsible for ensuring safety, or to policyholders. Nor do insurers operationally cooperate with ongoing community efforts at fire prevention. For example, one well-known anti-arson group undertook a program to prevent many of the most notorious properties in New York City from getting fire insurance. According to a 1985 article in Citizen Participation magazine, the group wrote to every insurance company known to provide fire insurance in its area, offering to share with those companies some of its own credible "early-warning" data as an aid in evaluating insurance risks. With the notable exception of the Liberty Mutual insurance company, the group's letters and phone calls drew what it termed an "unenthusiastic response." According to the article, other groups which also offered to work with insurers reported similarly disappointing results, "raising suspicions that some insurance companies don't much care about inner-city arson, so long as the premiums keep rolling in to cover it."

In addition to exchanging information and more strongly advocating fire safety measures, Hemenway suggests that insurers should offer policyholder discounts to encourage fire prevention. For example, only in the past few years have residential insurers included discounts for smoke detectors and for not smoking, and these discounts have neither been large nor well-publicized. Such discounts should be expanded to include use of less dangerous wiring and heating systems and for non-flammable furnishings.

c. Products:

It is estimated that nearly 100,000 deaths and millions of injuries each year are product-related, and are occurring at increasing rates. There are many ways insurance companies can function to control and minimize these hazards which cause death and injury.

For example, by implementing a structured disclosure program, insurance companies can do a great deal to assist those responsible for making products or services safer. According to safety research consultant David V. MacCollum, former president of the American Society of Safety Engineers, insurance companies should be collecting data on equipment, identifying injuries by

particular hazards, and maintaining a central data bank on hazard information, narratives of occurrences and available safeguards. For each claim or disputed injury, insurance companies should be routinely identifying the product hazard or unsafe condition which resulted in the claim, including the make and model of any product that served as the host for the hazard, or any chemical that could cause toxic injury. Companies should publish annual summaries of all death or injury-related occurrences, assuring public access to this information. These data are crucial for regulatory agencies, for those injured by such products, and for the populace so they may be alerted to unsafe products and conditions.

Internally, insurance companies with multiple lines, like workers' compensation and product liability, should forward information regarding hazards and equipment from one line to another. In addition, information about hazardous conditions and products and those which repeatedly cause serious harm should be communicated to law enforcement officials, as well as advertised to the public.

Insurance companies should also require implementation of hazard prevention measures as part of the insurance contract, particularly after a claim is submitted and specific hazard prevention measures identified. After a legitimate claim is paid, the insurer should routinely conduct a hazard analysis of the product or unsafe circumstance.

The insurance industry's lack of concern in controlling even the most serious hazards that the industry insures, was clearly evident during the House Subcommittee on Surface Transportation of the Committee on Public Works and Transportation hearings, May 19, 1988, on the transportation of hazardous materials. There are 500,000 shipments of hazardous and toxic materials moved each day through, what Rep. Douglas Applegate called "an archaic hazardous materials transportation system." DOT reported incidents of hazardous spills in 1986 were 5,700, and the Office of Technology Assessment says that as many as 50 percent of incidents are not reported.

Twenty-five witnesses testified at this hearing, including generators of hazardous wastes (e.g., the chemical manufacturers and corporations like DuPont); transporters of hazardous wastes (e.g., truckers, shippers); emergency management specialists (e.g., the Federal Emergency Management Agency,); and state and local government associations (e.g., National Governors Association). Not one insurance company nor insurance industry representative testified or even filed materials for the record.

d. Smoking

According to findings reported by PrideMark Young & Simon, smokers cost insurance companies 54% more for health care than do non-smokers. It is a mass tragedy that the life and health insurance industries did not crusade against cigarette smoking promotions and establish anti-smoking clinics years ago. Over

Letter to James P. Lynn, Page 10.

the years, Reader's Digest did far more in this area than did insurers such as Metropolitan, Prudential, the Equitable and John Hancock.

According to safety research consultant MacCollum, "If the existence of an effective hazard prevention program within an institution were used as the foremost criteria for providing underwriting coverage for workers' compensation, product liability, public liability, and other such insurance, we would not, today, need to be addressing the problem of exorbitant insurance rates." With their tremendous assets and soaring profits, insurance companies have a great opportunity to contribute to the advancement of health and safety by working to eliminate or reduce hazardous products, services and conditions. And they will reduce their claims costs in the process.

Instead of a major commitment by Aetna in these directions, your company is spending large sums to prejudice public opinion against the rights of injured persons to plead before juries for justice. Presently, in at least four states -- Colorado, Louisiana, St. Louis and upstate New York -- you are spending many policyholders' dollars in full page newspaper ads and electronic media spots. The content of these ads are replete with wild misrepresentations that do not reflect the regular disposition of cases in the courts. These ads are far, far less fair than would be an ad depicting Aetna's lengthy coverup of its knowledge about the Dalkon Shield mutilations as being explicitly representative of the entire insurance industry's practices.

Is this the way Aetna wants to spend money -- caricaturing the American legal system better than any Kremlin propagandist could do? Does Aetna want to provoke an aroused public against its outrageous distortions or would it rather enlist an aroused public into loss prevention project after project -- ranging from motor cycle helmet use to safer motor vehicles, medical devices and pharmaceuticals? Let's hear from you, Mr. Lynn. Which specific projects do you wish to have your company work on, that are mentioned in this letter, for results, not rhetoric?

Sincerely,

/s/

Ralph Nader



Law and Public Affairs Division
51 Farmington Avenue
Hartford, CT 06155

RECEIVED
FEB 10 1989
FBI - BOSTON

February 8, 1989

Mr. Ralph Nader
Center for Responsive Law
P.O. Box 19367
Washington, DC 20036

Dear Mr. Nader:

Jim Lynn asked me to respond to your recent letter.

We couldn't agree more that the insurance industry can help to improve health and safety in America. But you are either unaware or you choose to ignore the major contributions the industry, generally, and Aetna, specifically, are making to public health and safety.

You charge that we "could be doing much more than simply complaining about legal, medical and auto repair costs." Ralph, we're doing a lot more than complaining.

As you and the plaintiffs' bar are well aware, we have done much more than "simply complain" about the skyrocketing costs of litigation. Unfortunately, when we work with coalitions across the country to reduce delay and waste in the civil justice system, you and the trial bar yell "foul." When we try to enter into a serious dialogue about the need for more fairness in the system, you say we're trying to take away victims' rights.

Why, when so many people from so many different perspectives are decrying our badly flawed tort system, do you uncharacteristically show no concern?

We cannot -- nor should we -- assume responsibility for every facet of safety, as you would have us do. As you must be aware, many of the nation's manufacturers now largely self-insure their products. Without the leverage that the underwriting process provides, we lack the influence to affect product design and marketing. In short, we cannot be held responsible for the safety of products that we do not insure. Nevertheless, I assure you we are aggressive in our efforts to prevent injuries and to promote health and safety.

Ralph Nader
February 8, 1989
Page 2

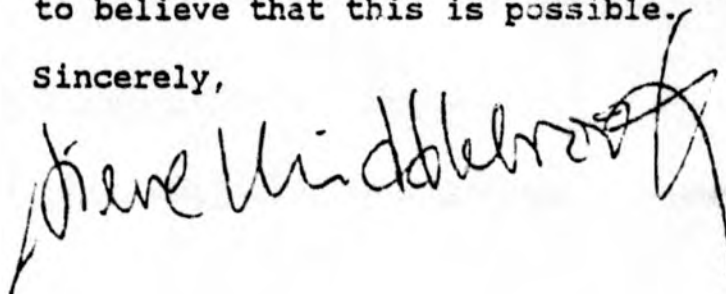
As an industry, we sponsor safety and loss prevention programs for millions of businesses, schools, towns and cities across America. Aetna alone has spent more than \$175 million in the past six years to make offices and factories safer for workers. Since 1979, Aetna alone has trained more than 300,000 police and fire officials in safety and investigation techniques. Our book, Fire and Arson Investigation, has been distributed all over the world and is used by the Federal Bureau of Investigation and the Bureau of Alcohol and Firearms for training recruits.

We work closely with employers on wellness programs, anti-fraud initiatives and cost-containment programs. The list of our activities is long -- very long. By any objective standards, it demonstrates our commitment to public health and safety. But your misperceptions about the insurance industry and your own very well-publicized campaigns against the industry and tort reform suggest either an inability or unwillingness to view us objectively.

There are, of course, problems facing our industry. The costs which drive what we must charge for our products are too high. The regulatory system is imperfect. But what's needed is for those with meaningful ideas to work together on solutions. That doesn't mean attributing every cost problem to insurer profitability or inefficiency. And it doesn't mean using insurers as scapegoats for what are complex societal problems.

We are ready and sincerely interested in working with others to reduce costs. If you share this interest, there may be reason to work together at some time in the future. But based on your statements to date, I'm not encouraged to believe that this is possible.

Sincerely,

A handwritten signature in dark ink, appearing to read "Gene Lindblom", with a stylized flourish at the end.

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MR JOANNE, RALPH NADER ASST, DLR

CENTER FOR THE STUDY FOR RESPONSIVE LAW RPT DLY MGN, DLR

2000 P ST NORTHWEST

WASHINGTON DC

PLEASE INFORM MR NADER THAT MR LYNN IS AWARE OF HIS MESSAGE HE ALSO
IS AWARE OF ANY FULLY ENDORSES BE WILLING TO ADDRESS INSURANCE ISSUES
CONSTRUCTIVELY AND FAIRLY WE WILL BE WILLING TO WORK WITH HIM UNTIL
THEN WE SEE NO POINT IN FURTHER DISCUSSION

W.U. 1201-SF (RS-69) KATHLEEN A MURRAY ASST VICE PRESIDENT CORPORATE MANAGEMENT


western union

Telegram

142 TRUMBULL ST
HARTFORD CT 06125

1214 EST
NNNN

C.15



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

March 15, 1989

MEMORANDUM

TO: Representative Sam Cotten

ATTN: David Rogers

FROM: Patricia Young *py*
Legislative Analyst

RE: Hawaii Court Annexed Arbitration Program
Research Request 89.306

You asked this agency to provide a copy of the Hawaii statute which allows for arbitration of personal injury claims. You requested a brief description of the process, as well as contacts in Hawaii for more detailed information.

The Hawaii Court Annexed Arbitration Program (CAP) is an alternative dispute resolution program designed to encourage settlements, to reduce litigants' costs, to expedite processing and resolution, and to reduce civil caseloads in the courts. Originally intended to handle comparatively small and simple personal injury cases, the CAP has expanded to include all tort cases with a probable jury award value of \$150,000 or less. The CAP is a mandatory, non-binding program.¹ Litigants may select a private arbitrator, or the arbitration commission administrator will assign one to hear the case and deliver a judgment. A litigant who wishes to appeal a judgment must do so within 20 days of the arbitrator's award. If the court does not alter the award by at least 15 percent in favor of the appealing party, the appealing party is required to pay reasonable costs and fees, costs of jurors, and attorney's fees up to \$5,000.

I have attached a copy of the enabling statute and rules, background information on the program, and caseload and result data. Contacts in Hawaii for more information are Ed Aoki, CAP arbitration administrator, at (808) 548-4380; Peter Adler, director of the Program on Alternative Dispute Resolution (ADR), at (808) 548-3080; and Dee Dee Letts, assistant director, at the same number.

I hope this is information useful. Please call if you have any questions or need further information.

Attachment

¹Exemptions from arbitration are considered by the arbitration judge upon request.

ADR TRENDS & ABSTRACTS

From the Hawaii State Judiciary / Program on Alternative Dispute Resolution

Vol 4, No 1

Honolulu, Hawaii

Jan/Feb/Mar 1988

C O U R T A N N E X E D A R B I T R A T I O N I N H A W A I I

A Special Report

As the Program on ADR begins its fourth year of operation, it is fitting that we provide a special report on Hawaii's Court Annexed Arbitration Program (CAP). This program was - and still is - one of the most important alternative dispute resolution experiments underway in the state. Because of its unique goal of reducing litigant costs and its high gatekeeping amount of \$150,000, the program is also of great interest nationally. We continue to receive many inquiries from other state and federal court jurisdictions asking how the program is progressing. We know this is also of great interest locally because of continuing debates over tort and insurance reform. In addition to our regular mailing list, therefore, we are sending copies of this issue to the 500+ attorneys in Hawaii who serve as CAP Arbitrators and to an expanded list of judges, court administrators, and elected officials. We look forward to any comments readers might have to offer and bringing you additional updates in the future. Peter S. Adler, Director, Program on ADR

Peter S. Adler
Director
Program on A.D.R.

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I. WHY COURTS ADOPT ARBITRATION

(The following article has been excerpted from COURT ORDERED ARBITRATION: A BRIEFING FILE published by the National Institute for Dispute Resolution in June, 1985)

Backlogs undermine faith in the efficiency of the courts. Plaintiffs in law suits are uncertain when their cases will be resolved. Defendants face prolonged uncertainty before knowing what, if anything, they will have to pay in damages. Both sides face mounting legal costs if their cases drag on. Some observers believe that delays harden the positions of litigants, encourage plaintiffs to hope for large settlements, and force cases into trials that are expensive for both the parties and the public. In sum, prolonged court delays unnecessarily tax both public and private resources and deprive litigants of the timely resolution of disputes which is among the most fundamental obligations of a just society.

Thus, there is a challenge to solve the problem of justice delayed - to adopt a method that has the criteria for offering prompt, relatively inexpensive, less formal and fair resolution of a great many civil court actions, while firmly preserving the procedural and substantive rights of all citizens involved in law suits.

Court-ordered arbitration is one method which, in recent years, has found great favor in meeting these criteria. It ~~interposes~~ mandatory but nonbinding rulings by arbitrators before civil cases may be pressed to trial. The key words are mandatory and nonbinding. In jurisdictions where court-ordered arbitration applies, an arbitrator or arbitrators hear the evidence of selected civil suits in a relatively informal setting with simplified hearing procedures and sometimes, a set time limit. Then they render a decision. That's the mandatory part. If one or more parties to the action refuses to accept the arbitrator's decision, the action then can be pursued through formal litigation. That's the nonbinding part. Citizens do not lose their rights to the full course of litigation if that is what they demand. The opportunity of having one's day in court is preserved, although there are disincentives for rejecting a judgment reached in arbitration and pursuing litigation. For example, a losing party may have to pay the attorney's fees of a courtroom opponent.

The promise of prompt resolution of disputes should not obscure the other benefits of court ordered arbitration. The overhead costs of resolving disputes are usually lower with arbitration than with litigation. The rules and procedures of arbitration are less rigid and formal than those in the courtroom. Arbitration often leaves fewer traces of acrimony among disputants once they have resolved their differences. Court-ordered arbitration, thus, is a beneficial tool for resolving disputes, whether court dockets are crowded or not.

Another important attribute of court-ordered arbitration is flexibility. Beyond these core propositions, programs differ from state to state, for example, in the causes of suits to which court-ordered arbitration may be applied; the ceiling of dollar amounts that can be involved in suits; the selection and payment of arbitrators; the disincentives to pursuing litigation; the level of involvement of the judiciary; or the point in the judicial process at which a case is referred to mandatory arbitration.

Court arbitration is now in operation in more than 20 state and federal jurisdictions. Its potential for reducing caseloads of courts and ensuring prompt resolution of many law suits is impressive. Some experts suggest that the widespread adoption could affect more than one half of the nation's total civil caseload.

II. COURT ARBITRATION IN HAWAII

by Peter Adler

In March, 1985 Chief Justice Herman Lum asked Judges Philip Chun and Ronald Moon along with various members of the First Circuit's Civil Rules Committee and the Judiciary's Program on ADR to explore the feasibility of establishing a mandatory, non-binding program of arbitration in Hawaii's State Courts. The initial goals, as charted by the Chief Justice, were to reduce the high cost of going to court for litigants, to speed up case processing for routine personal injury cases, and to help prevent the buildup of civil delays.

This planning group began its investigation and, after 10 months of research and development, inaugurated the start of Hawaii's CAP. As originally conceived, the program was to be created as an experiment and pilot program launched under the Supreme Court's rule-making powers. It would focus only on personal injury cases with a probable jury verdict value of \$50,000 or less.

To implement the program, a governing body - the Judicial Arbitration Commission - was established by the Supreme Court and the following members appointed by Chief Justice Lum: Judge Ronald Moon (Chairperson and Arbitration Judge); James E. Duffy, Jr., Esq.; Robert Grantham; Sharon R. Himeno, Esq.; James E. Kawashima, Esq.; Walter S. Kirimitsu, Esq.; Frank Lockwood, Esq.; Christopher M. McKenzie, Esq.; Kenneth Okamoto, Esq.; Gerald Y. Sekiya, Esq.; and Robert S. Toyofuku, Esq. Appointed as Advisors to the Commission were Warren Price III, Esq.; Raymond T. Tam, Esq.; and Dr. Peter S. Adler.

In its earliest form, the CAP was designed to handle comparatively smaller and simpler cases brought into arbitration by either a plaintiff's or defendant's demand. To implement the program, a small staff headed by Arbitration Administrator Edwin Aoki was hired. Office procedures were established and rules and forms were published with the assistance of the Hawaii Law Institute. A panel of approximately 100 pro-bono Arbitrators was selected and trained by the Commission and seminars acquainting Hawaii's practicing lawyers were held. After CAP operations actually commenced in February, 1986, the CAP began processing 15 to 20 cases per month.

In July, 1986 - and as part of its special summer session - the State of Hawaii Legislature passed Act 2 pertaining to tort and insurance reform. This statute gave the CAP a basis in law and mandatorily expanded the program's focus to include all tort cases and not just personal injuries. It also raised the arbitration threshold limit to \$150,000 which would theoretically make 80% of all First Circuit tort filings arbitration-eligible.

Following the initial passage of Act 2, the Judicial Arbitration Commission studied a variety of ways of implementing the new legislatively imposed limits. Data on the existing arbitration program and on past and prospective civil caseloads were analyzed and court arbitration programs in other jurisdictions were consulted for advice. What emerged from this second round of planning was the CAP's present features which are unique in the United States. These features include:

- "Gatekeeping" procedures that presume all cases to be arbitration eligible and that put the onus of seeking exemptions from arbitration on litigants.

- A joint (arbitrator and court) case management model that empowers arbitrators to control discovery.
- A required pre-hearing conference 30 days after an arbitrator has been selected or assigned.
- An option for litigants to select and pay for their own arbitrators rather than using the court's panel.
- Continued emphasis on systematic experimentation and evaluation.

On May 1, 1987, the above features, as embodied in amended Rule 34 of the Hawaii Rules of Court, took effect in the First Circuit. In August, 1987 the use of a formal "comparison" group for research purposes was inaugurated. This research is long-term and will continue under a three-year contract with the University of Hawaii. In October and November, 1987 the arbitration program was expanded to include the Second, Third, and Fifth Circuits making Hawaii the first state in the nation to implement court-ordered arbitration on a state-wide basis.

III. HAWAII'S COURT ARBITRATION RULES: A SYNOPSIS

by Pamela Gring

Rule 1. The Court Annexed Arbitration Program

A mandatory, non-binding program for certain civil cases.

Rule 2. Intent of Program and Application of Rules

Purpose is to obtain prompt, equitable resolution of civil matters designated by the Judicial Arbitration Commission. Not applicable to other forms of arbitration (e.g. private arbitration agreements, arbitration under existing statutes). The arbitration rules are intended to be discretionary and informal.

Rule 3. The Arbitration Judge

A Circuit Court judge appointed by the Chief Justice shall determine all disputed issues under the Rules.

Rule 4. The Judicial Arbitration Commission

Established by the Chief Justice to oversee the Arbitration program. It selects and trains arbitrators; hires, supervises and evaluates the staff; and promulgates rules necessary to carry out its responsibilities.

Rule 5. The Arbitration Administrator

Appointed by the Commission and is responsible for the operation and management of the Program.

Rule 6. Matters Subject to Arbitration

Tort cases with a probable jury award value of \$150,000 or less may be accepted at the discretion of the Commission. Other civil case may be submitted if parties agree and the Arbitration Judge approves. Parties can agree to be bound by any arbitration ruling. The Judge may accept or remove an action for good cause.

Rule 7. Relationship to Circuit Court Jurisdiction and Rules; Form of Documents

Cases within the jurisdiction of the Circuit Court remain so for all phases of the proceedings. Except for authority expressly delegated to others, issues will be determined by the responsible Circuit Court. Where applicable, rules of the Circuit Court and civil procedure apply. All parties in an action submitted to arbitration are parties to the arbitration unless dismissed by the Judge.

Rule 8. Determination of Arbitrability

All qualifying tort cases are automatically in the Program. Exemptions from arbitration will be considered if the request is supported by adequate evidence. A case may be removed or readmitted to the Program with proper factual support. The Arbitration Judge has final say on

arbitrability. The Judge has discretion to impose reasonable costs and attorney's fees against parties who unreasonably try to remove a case from the Program.

Rule 9. Assignment to Arbitrator

After each party strikes 2 out of 5 possible arbitrators, the Administrator appoints an arbitrator from the remaining list. When parties are added after arbitrators are chosen, objections may be made by those parties. Parties may select private arbitrators.

Rule 10. Qualifications of Arbitrators

The Commission maintains a panel of arbitrators who have completed an orientation and training program. Issues concerning disqualification are referred to the Commission for final, non-reviewable determination.

Rule 11. Authority of Arbitrators

Arbitrators have general powers of a court. A challenge to an arbitrator's authority will be made to the Administrator, who makes a ruling in due course.

Rule 12. Stipulations

Stipulations must be in writing, signed by the counsel or parties, and filed with the arbitrator.

Rule 13. Restrictions on Communications

Individual parties may not discuss the case with the arbitrator unless other parties are notified.

Rule 14. Discovery

The extent of discovery is governed by the arbitrator. HRCF regulates the type of discovery, which may be modified by the arbitrator.

Rule 15. Scheduling of Hearings; Pre-hearing Conferences

Arbitration must be completed within 9 months from the date of service to the last defendant. The arbitrator must hold a pre-hearing conference within 30 days of case assignment.

Rule 16. Pre-hearing Statement

Thirty days before the arbitration hearing the parties must submit a statement disclosing probable evidence and witnesses to be used.

Rule 17. Conduct of Hearing

The arbitrator has discretion over conduct of the hearing. No transcript or recording is permitted.

Rule 18. Arbitration in the Absence of a Party

Arbitration may proceed when a duly notified party is not present or fails to obtain a continuance.

Rule 19. Form and Content of Award

Arbitrator's awards must be in writing, signed and on proper forms. Findings of Fact and Conclusions of Law are not required.

Rule 20. Filing of Award

Awards must be filed with the Administrator within 7 days of the conclusion of arbitration or 30 days after receiving final memoranda of counsel.

Rule 21. Judgment on Award

If no party files a written Notice of Appeal and Request for Trial De Novo within 20 days, the award is considered as a final judgment and is not appealable.

Rule 22. Request for Trial De Novo

A party may file a request for trial *de novo* within 20 days, after which the case will be set for trial.

Rule 23. Procedures at Trial De Novo

An arbitration award will be sealed if a trial *de novo* is requested. Juries will not be informed of arbitration proceedings.

Rule 24. Scheduling of the Trial De Novo

Cases transferred to the Program maintain approximately the same place as they would on the civil trial docket.

Rule 25. The Prevailing Party in the Trial De Novo; Costs

To prevail the party appealing must improve their award by 15% or more.

Rule 26. Sanctions for Failing to Prevail in the Trial De Novo

Sanctions include: reasonable costs and fees, costs of jurors, and attorney's fees (\$5,000 or less).

Rule 27. Effective Date

Rules apply to all 1st Circuit cases filed after February 15, 1986. The Program became effective in the 2nd Circuit as of October 1, 1987, in the 3rd Circuit as of October 15, 1987, and in the 5th Circuit as of November 1, 1987.

IV. CASELOAD REPORT: FEBRUARY, 1986 TO DECEMBER, 1987

by Edwin S. Aoki

This progress report covers First Circuit CAP activity from the program's start-up on February 15, 1986 through December 31, 1987. It reports the status of nearly 1,000 cases. In the beginning - what we call Phase I - only personal injury cases with a probable jury verdict value of \$50,000 or less were eligible for the program. The arbitration program was, de facto, "voluntary" because cases could only enter if one of the parties demanded it.

On May 1, 1987 major changes were made to the CAP as a result of a law passed by the Special Legislative Session on Tort Reform in June, 1987. These changes (1) expanded the jurisdictional amount from \$50,000 to \$150,000 and made the arbitration more "mandatory". All tort cases were now viewed as arbitration eligible and automatically "in" the program unless a plaintiff or defendant could demonstrate that the case had a value in excess of the jurisdiction and should be out.

Phase I (Cases filed February 15, 1986 to April 30, 1987)

In Phase I, the CAP admitted a total of 278 cases. 241 were successfully terminated. By terminated, we mean they were either settled, dismissed, or an award was rendered after an arbitration hearing and the case did not go to trial. A few cases were either removed from the Program because the value of the case had increased from the date of entry or were removed to a Federal Court.

Of the 241 cases that were terminated, 166 (69%) were concluded by the way of settlement by the parties, usually with the assistance of an arbitrator but prior to a formal arbitration hearing. Cases terminated by way of settlement took an average of 207 days. 53% of all cases took longer and 47% took less time. The average amount of settlement of these cases was \$20,863. The total of all settlements was \$3,400,792.

60 cases were arbitrated to the point of award. Cases which went to an arbitration award took an average of 258 days. 42% of all these cases took longer and 58% took less time. The average arbitration award was \$24,516. The total amount of awards filed was \$1,056,704. The highest individual award to a plaintiff was \$93,103. The lowest was \$2,926. 9 awards of zero (\$0) were made.

There are currently 37 cases from Phase I pending.

Phase II (Cases filed May 1, 1987 to December 31, 1987)

Since Phase II began, the CAP has experienced a dramatic increase in the number of cases entering the program. Part of this is due to the raise in jurisdictional limit and part of it to the CAP's "gatekeeping" mechanisms of presuming cases eligible. During this time, the CAP received 668 cases or an average of 84 cases per month.

Of these 668 cases, 151 (23%) were terminated either by way of a settlement, award or dismissal. The low termination rate reflects the fact that many of these cases are "fresh", that is, they have only recently entered the arbitration system. Many of these cases are awaiting assignment of an arbitrator which normally takes 60 days from the date a complaint is filed, served, and answered.

Of the 151 cases that were terminated, 63 (42%) were terminated by way of a settlement. The average time to a settlement was 102 days with 45% of these cases taking longer and 55% taking less time. The average settlement amount of these cases was \$29,842. The total amount of all settlements was \$1,880,108.

Of these Phase II cases that have terminated, seven were by awards. The average time involved was 142 days with 45% taking longer and 55% taking less time. The average amount of these awards was \$53,962. The highest award was \$131,286, and the lowest was \$9,186. Thus far in Phase II, there have been no zero (\$0) awards. There are currently 517 pending cases under the CAP's Phase II procedures.

Summary: All Cases

Total Cases Received in the CAP.....	946
Total Cases Terminated.....	392
Total Pending Cases.....	554
Total Amount of All Settlements.....	\$5,280,900
Average Amount of All Settlements.....	\$23,366
Average Lapsed Time for All Settlements.....	178 days
Total Amount of All Awards.....	\$1,434,442
Average Amount of All Awards.....	\$28,126
Average Lapsed Time for All Awards.....	245 days
Number of Awards.....	67
Number of Trial de Novo Requests.....	23
Number of Appeals that have Gone to Trial.....	0

V. RESEARCH AND EVALUATION: PRELIMINARY FINDINGS

by John Barkai and Gene Kassebaum

A team of researchers from the University of Hawaii that includes ourselves and others is currently studying and evaluating Hawaii's Court Arbitration Program (CAP). Hawaii's CAP has a number of unique features including the highest dollar ceiling in the country (\$150,000), early intervention in cases, and strong limitations on discovery as a way of reducing litigant costs. Because of these features, the program and its evaluation is of great interest nationally.

The research project is located at Department of Sociology, Porteus Hall 237, University of Hawaii at Manoa, Honolulu, Hawaii 96822. It is being funded by a three-year contract from the Judiciary and in-kind contributions from the Program for Conflict Resolution, the Sociology Department, and the William S. Richardson School of Law, all of the University of Hawaii at Manoa. The principal researchers are Sociology Professors Gene Kassebaum, David Chandler, and Law Professor John Barkai.

Our study of the CAP is really a study of two groups of cases: those assigned to the arbitration program and a "comparison group" of cases assigned to regular litigation. All tort cases are assigned to CAP when they are filed. Eligible cases are then assigned to either arbitration or litigation. CAP currently assigns, by random numbers, one-half of the cases to arbitration and one-half to litigation.

A comparison group of cases is necessary to measure the effects of arbitration against cases in regular litigation. It is also needed in order to develop an adequate database on cases in ordinary litigation. Current court records are only partially useful in this regard because they are geared to tracking cases but not to evaluating alternatives.

Data collected for the evaluation are being kept in the strictest confidence. Only aggregated information will be released, and no information about any specific case will be made public. Evaluation data will be collected from 1) court and arbitration records, 2) surveys sent to lawyers and arbitrators for cases both in arbitration and regular litigation, and 3) inquiries to insurance companies, discussions with judiciary employees, and interviews with lawyers.

The Survey of Closed Cases from Phase I:

It must be strongly emphasized that this brief article only reports the findings of the first surveys of arbitration cases in Phase I (\$50,000) program. Phase II (\$150,000) began in May, 1987. Although some Phase II cases have terminated, no Phase II case has reached the nine month deadline. Consequently, not enough cases have terminated to provide any meaningful data on Phase II. Data which will be collected later in Phase II may be similar to or different from the data reported here.

In our current work, surveys were sent to all award cases (over-sampled because they have more information) and one out of four settlements in Phase I. Approximately 300 surveys were sent to 56 awards and 170 settlements. These cases represent all the cases that had terminated at the time the surveys were distributed. 60% or 200 surveys were returned (66 plaintiff, 66 defense, and

and 68 arbitrators). The information presented here is thus drawn from 186 usable survey forms (61 plaintiff, 64 defense, and 61 arbitrators). Approximately one-half of the sample comes from award cases and one-half comes from other cases. To give a more accurate view of the program, therefore, the tabulations are weighted according to standard statistical methods to produce data in proportion to the actual number of cases terminating in settlements and in awards.

Findings on Phase I (\$50,000) Cases:

Mode of Termination and Arbitrator Involvement. Approximately 20% of the cases that enter the program go all the way to an arbitration award and 80% settle before award. Arbitrators are actively involved in half the cases. 28% settle with the arbitrator's assistance and 22% receive an arbitrators award. In the other half of the cases there is either no arbitrator appointed or no work for the arbitrator. 20% of all cases settled before an arbitrator was involved, and 30% settled after the arbitrator was involved, but without the arbitrators assistance. The award cases can be appealed to a trial de novo, but so far appeals have either settled or are still pending.

Lawyer and Client Satisfaction. Overall, 76% of lawyers were satisfied with the way their case was handled in the program, but there was more criticism and dissatisfaction from defense lawyers than from plaintiff lawyers. Nearly all (84%) plaintiff lawyers were satisfied with CAP in the particular case surveyed; 71% of defense lawyers reported being satisfied. Not surprisingly, satisfaction also differed depending on whether the case settled or went to award. 100% of plaintiff lawyers and 90% of defense lawyers whose cases settled were satisfied; 72% of plaintiff lawyers and 38% of defense lawyers whose cases went to an award were satisfied.

Lawyer satisfaction is highly correlated to the lawyer's perception of whether the award was similar to what the lawyer thought might be the trial verdict. When cases proceeded to awards, more plaintiff lawyers (64%) than defense lawyers (44%) thought the awards were similar to what the verdict would have been at trial. The assumption that the case would have gone to trial is quite hypothetical. In Hawaii only three percent of personal injury cases are tried. 87% of plaintiff lawyers who saw the awards as similar to verdicts were satisfied with the arbitration program; only 40% who saw the awards as different from trial were satisfied. Defense lawyers had very similar impressions. 82% of defense lawyers who saw the awards as similar to verdicts were satisfied with the arbitration program; only 36% who saw the awards as different from trial were satisfied.

Interestingly, both plaintiff and defense-counsel estimated 74% of their clients were satisfied and both estimated that their clients were 88% satisfied with settlements and 8% dissatisfied. Differences were more dramatic for awards. Plaintiff lawyers estimated that 72% of their clients were satisfied and 28% dissatisfied with the award. However, defense lawyers estimated that 52% of their clients were satisfied and 48% dissatisfied with the award. We would like to know how satisfied the insurance companies are. They are the true clients for most defense lawyers.

Speed of Disposition. Overall, 22% of the lawyers surveyed believed that if their case had not been in the CAP it would have taken longer to terminate. The views of plaintiff and defense lawyers differed again. 87% of plaintiff lawyers thought the case would have taken longer if it was not in the program; 56% of defense attorneys thought it would have taken longer.

Discovery. A major program goal is to reduce expense for litigants by reducing discovery. Discovery did appear to be reduced. 83% of plaintiff lawyers, 67% of defense lawyers, and 80% of arbitrators reported discovery reductions. Discovery can be reduced either because the lawyers agree to limit discovery or because the arbitrator denies requests for discovery. Arbitrators reported that they only denied discovery requests in 9% of cases, which suggests that discovery is being reduced mainly through voluntary compliance by the lawyers. It is important to note that only 1% of plaintiff lawyers and 11% of defense lawyers reported that discovery reduction affected the outcome of the case.

Discovery costs also were examined. For plaintiff lawyers, discovery was less than \$100 in 31% of the cases and less than \$400 in 68% of the cases. Only 7% of plaintiff lawyers reported discovery expenses over \$1000. For defense lawyers, discovery was less than \$100 in 43% of the cases and less than \$400 in 57% of the cases. Only 8% of defense lawyers reported discovery expenses over \$1000. At this time we cannot yet estimate how much the program has saved in discovery costs although insurance companies already may know the answer. We will not know the discovery costs for ordinary litigation until the comparison cases are surveyed. However, 81% of plaintiff lawyers and 54% of defense lawyers reported that the case would have cost more if it had not been in CAP.

Summary of Findings on Phase I (\$50,000) Cases:

Satisfaction. Generally, lawyers were satisfied with the program, although more plaintiff lawyers were satisfied than were defense lawyers. As might be expected, more lawyers were satisfied with their voluntary settlements than with the awards by the arbitrators.

Speed of Disposition. Most plaintiff lawyers believed that if their case had not been in the arbitration program it would have taken longer to conclude. Only about half of the defense lawyers believed that the arbitration program was faster than ordinary litigation.

Discovery and Cost Reduction. Plaintiff lawyers, defense lawyers, and arbitrators, all reported that the program reduced discovery and that discovery reduction did not affect case outcome. Most plaintiff lawyers believed that if their case had not been in CAP it would have cost more to terminate. Only about half of the defense lawyers believed that the arbitration program was less costly than ordinary litigation.

In keeping with the scope and work of our study, we will continue to evaluate the development and impact of Hawaii's CAP. Future reports will include cases that entered the program after May 1, 1987.

VI. AKAMA v. TSUDA: A CASE STUDY

by Cynthia Lee

(The following story chronicles an actual case handled in the CAD. Information about this case was received from attorneys Wayne Sakai, Paul DiBianco, and Mark Desmarais. Only the names of the parties and the defendant have been fictionalized.)

The Facts:

On March 17, 1984, Sylvia Akama was driving on Wai'ale'ale Avenue near Kahala Mall Shopping Center. Suddenly the car in front turned up a ramp into the shopping center. Sylvia braked and then stopped to prevent hitting the car in front. Samuel Tsuda, who was directly behind Sylvia, was not as lucky. He ended up running into her and causing one of the most common kinds of auto accidents: a rear end collision.

Two years later on April 12, 1986, after consulting various doctors and chiropractors, Sylvia Akama had her attorney, Paul DiBianco, file a Complaint against Samuel Tsuda. The allegations included among other things "severe and lasting physical injuries", "great pain of body and mind", and "loss of income". Samuel Tsuda's attorney, Mark Desmarais, answered this complaint on May 14, 1986.

The Case In Arbitration:

On July 13, 1986, Akama v. Tsuda entered into the Court Arbitration Program (CAP). In effect, the two parties agreed to put their case on a track system that continued their circuit court case but also sought to resolve matters without the time, expense and complications of a full circuit court trial. Since court arbitration is non-binding, the parties did not exclude the possibility of a trial. That right was retained if either side were dissatisfied with the results of arbitration.

On August 12, 1986, attorney Wayne Sakai was selected and confirmed as Arbitrator of the case. His deadline for filing an award was April 18, 1987, nine months after the agreement to enter into arbitration was filed. As required, Sakai sent a letter to both parties to schedule a pre-hearing conference within thirty days after his appointment. In his letter, he asked both attorneys to submit, two days before the conference, written statements of facts and issues, and a summary of discovery items.

According to Arbitrator Sakai, the liability of Samuel Tsuda was not a major issue. The major point of the case was the extent of Sylvia Akama's injuries and how much she should be awarded in compensation. Thus, much of the discovery allowed by Sakai involved medical examinations by both parties' doctors and submittal of these doctor's reports to Sakai. These examinations and reports were considered important enough that the case was extended by 60 days to June 18, 1987 to allow for a test that defendant Tsuda's doctor thought was necessary.

As the case proceeded, Arbitrator Sakai encouraged the two parties and their attorneys to reach a settlement. Whenever possible, he suggested ways to economize and speed up the process of resolution. He did not, however, get directly involved in negotiations because he felt that the two parties were too far apart in their figures. Since he might eventually end up hearing the case, he did not

actually conduct mediated settlement discussions.

After several pre-hearing conferences, the case did go to a formal arbitration hearing. The hearing was like a trial, with direct and cross-examination of witnesses and parties, and the introduction of evidence. On June 18, 1987, exactly 11 months after the Ahama v. Tsuda case entered into arbitration, Ahama was awarded special damages of \$5,902.83 and general damages of \$28,000. Defendant Tsuda had 20 days to appeal this decision and to ask for a jury trial but, declined to do so. According to his attorney, Mark Desmarais, Tsuda did not want to risk the sanctions of having to pay costs and fees, attorney's fees of up to \$5,000, and the cost of jurors if he could not better the jury trial outcome by 15%.

Reflections by the Attorneys:

The three attorneys in this case, Arbitrator Wayne Sakai, Plaintiff's attorney, Paul DiBianco, and Defendant's Attorney, Mark Desmarais, have all performed the roles of Arbitrator, defense attorney, and plaintiff's attorney. They felt that the Arbitration Program was, in general, accomplishing its goals of speeding up the process of civil litigation and doing it more economically and with results fairly close to circuit court awards.

Paul DiBianco summarized the assessments of all three attorneys involved in this case:

- 1) The process was faster so that the parties had a resolution of the dispute sooner. They didn't have to remain in litigation and prolong their anxiety over what the outcome might be.
- 2) The simpler procedures allowed for more informal discovery procedures and cut down the costs and fees, particularly those related to experts.
- 3) The informal proceedings allowed both the parties, and their witnesses, to feel more comfortable, especially since Arbitrator Wayne Sakai did not wear a black robe.

From Defendant's point of view, Samuel Tsuda and the insurance company expressed satisfaction with the handling of this case by the CAP. Samuel Tsuda was happy that the process was faster and simpler and the insurance company was pleased that costs were lower.

VII. LEADERSHIP AND MANAGEMENT

Judicial Arbitration Commission

Judge Ronald T.Y. Moon, First Circuit, Chairperson
Judge Boyd P. Mossman, Second Circuit
Judge Shunichi Kimura, Third Circuit
Judge Kei Hirano, Fifth Circuit
James E. Duffy, Jr.
Robert Grantham
Sharon R. Himeno
James Kawashima
Walter S. Kirititsu
Frank T. Lockwood
Christopher P. McKenzie
Kenneth T. Okamoto
Gerald Y. Sekiya
Robert S. Toyofuku

Advisors to the Commission:

Peter S. Adler
Warren Price, III
Raymond J. Tam

Neighbor Island Arbitration Committees

Hawaii

Lawrence W. Cohn
Kenneth A. Ross
Diana L. Van De Car
Andrew P. Wilson

Kauai

Kurt R. Bosshard
Daryl Y. Dobashi
Raymond G. Duvauchelle
Calvin K. Murashige

Maui

James Krueger
B. Martin Luna
Robert M. Monden
Shackley Raffetto

Arbitration Administrators

Hawaii - Eleanor Mirikitani
Kauai - Steven S. Okihara
Maui - Robert M. Monden
Oahu - Edwin S. Aoki

VIII. FIRST CIRCUIT ARBITRATORS

Abbott, Ethan D.B.
 Abe, Fred Y.
 Abe, Michael K.
 Agena, Melvin Y.
 Agnata, Victor Jr.
 Ahu, Elvin P.
 Akama, Dudley G.
 Akiba, Lorraine d.
 Albu, Ronald
 Alcantara, Leonard F.
 Alexander-Taylor, Amy
 Alston, Paul
 Aluli, Yuklia
 Aoki, Paul S.
 Ashford, George W. Jr.
 Au, Ronald G.S.
 Ayabe, Sidney K.
 Bain, Elton J.
 Bays, A. Bernard
 Bell, Roy J.
 Bendet, Edward R.
 Bernstein, Mark D.
 Bettencourt, David
 Sigelow, Bruce C.
 Blaustein, Mark P.
 Bocken, R. Charles
 Bogert, Philip D.
 Border, Patrick W.
 Bordner, William A.
 Brandt, George W.
 Broder, Sherry P.
 Burke, Edmund
 Carnay, Thomas I. Jr.
 Carroll, Benjamin L. III
 Chang, Gary W.B.
 Chang, Howard T.
 Chang, Kevin S.C.
 Chang, Louis L.C.
 Chang, Nelson S.W.
 Chang, Robert H.K.
 Chang, Roy K.S.
 Char, Peter C.P.
 Chee, Kevin S.W.
 Ching, Randall Y.C.
 Ching, Wesley H.H.
 Choi, Cedric
 Chong, Robert A.
 Chew, Steven J.T.
 Chey, Malcom W.E.
 Chu, Harold
 Chuck, Gregory W.
 Chun, Jarrold Y.
 Chun, Richard C.F.
 Chun-Moon, Lowell K.Y.
 Chung, Randall Y.S.
 Chung, Steven K.S.
 Cook, Thomas E.
 Corpe, Randolph L.
 Coogrove, Gail Y.
 Cowan, Stuart M.
 Crumpton, Charles W.
 Cuskaden, Everett
 Davis, Mark S.
 Davis, Walter
 Desmarais, Mark S.
 Devens, Paul
 Dessant, David J.
 Dibianco, Paul E.
 Duffy, James E. Jr.
 Durbin, Paul J.
 Earle, Jacqueline L.S.
 Edmunds, John S.
 Eggers, William J. III
 Eichor, Rick J.
 Englishart, C. Andrew
 Estes, James T.
 Ezra, David A.
 Fairbanks, David L.
 Fell, Charles F.
 Fenton, Ashley K.
 Fern, Dennis K.
 Ferrara, Christopher D.
 Fong, Peter
 Fong, Valerie W.H.
 Fong, Wesley F.
 Fong, Janel D.
 Fray, Philip S.
 Fried, L. Richard Jr.
 Fritz, Collin M.
 Furusue, Craig K.
 Furutani, Miles S.
 Futa, Janice T.
 Garcia, Max M.
 Gibson, Michael W.
 Gilroy, William H. Jr.
 Gaudet, Larry
 Gaudin, Kai
 Gaudreau, Howard
 Gouber, H. William Jr.
 Greenay, H. Burnham
 Gronau, Kurt A.
 Guttman, Steven
 Hall, David W.
 Hare, C. Michael
 Hayashi, Leslie Ann
 Hae, Alfred H.H.
 Hae, Sherman S.
 Henderson, Harvey E. Jr.
 Hiatt, Jerry
 Hiatt, Lynn
 Higa, Warren H.
 Higashi, Jeffrey Y.
 Himeno, Sharon R.
 Himmelman, John D.
 Hirai, Colleen K.
 Hirai, Richard H.
 Hiramatsu, Beverly L.K.
 Hirono, Marie K.
 Hiseaka, Steven
 Hoe, Allen K.
 Hoka, Richard L.
 Hong, Michael D.
 Horie, Walter K.
 Howell, A. Peter
 Hughes, Roy F.
 Huthart, Neil F.
 Hunt, William S.
 Ichida, Wesley W.
 Ikada, Walter M.
 Ikada, Wesley H.
 Ikahara, Archie T.
 Ikai, Clayton C.
 Indie, Michael T.
 Ing, Dennis A.
 Ishida, Lincoln J.
 Ito, Alvin T.
 Ito, Ernest A.
 Iwanaga, Michiro
 Izumi, Francis M.
 Jaffe, Edward A.
 Jarvis, Garard Aulama
 Jim On, Shelton G.W.
 Johnson, Solomon E.
 Johnston, Mary Blaine
 Jones, Ward D.
 Kakazu, Cheryl K.
 Kaneko, Stuart A.
 Kanetake, Stanley T.
 Kaolulo, Archibald C.K.
 Kawachika, James A.
 Kawashima, James
 Kikina, Wayne
 Kassner, Robert C.
 Kidani, Grant K.
 Kim, Alexander Y.H.
 Kim, Bruce S.
 Kim, Dewey H. Jr.
 Kim, Michael T.I.
 Kimura, George Y.
 Kimura, Glenn I.
 King, Adrienne S.
 King, James A.
 King, Samuel P. Jr.
 Kirimitsu, Walter
 Kitamura, Henry T.
 Kleintop, Charles
 Kobayashi, Bert T.
 Kodani, Roy M.
 Komatsubara, Kerry M.
 Komaiji, John T.
 Kondo, Wray
 Koraka, Mervyn M.
 Koyanagi, Faye M.
 Kugisaki, Craig T.
 Kuniyuki, Ken T.
 Kupchak, Kenneth R.
 Kurren, Barry M.
 Kuwasaki, Larry T. Jr.
 Lee, John R.
 LePountaine, Ralph R.
 Lau, Jeffrey D.
 Lau, Kenneth
 Lau, Laurence K.
 Lawhn, James H.
 Leavitt, James T. Jr.
 Lebb, Edward R.
 Lee, Dale W.
 Lee, Douglas T.Y.
 Lee, Stephen W.H.A.
 Leong, Robin J.
 Levinson, Steven H.
 Libkuman, Ronald D.
 Lilly, Michael A.
 Lin, Kuen Mi
 Le, David
 Lockwood, Frank
 Lockwood, John A.
 Loo, George
 Louis, David M.
 Love, Chad P.
 Low, Donald H.C.
 Lum, Leslie W.S.
 Macdonald, Stephen R.
 Maciszewski, Felix A.
 McLaren, Alexander T.
 Mah, Stanley S.
 Marrash, Alexander C.
 Marsh, Michael R.
 Marutani, Allen I.
 Masui, Stanford H.
 Matsui, G. W.M.
 Matsumoto, Colbert
 Matsumoto, Robert K.
 McCarthy, Michael F.
 McKenzie, Christopher
 McPheters, Howard
 Morse, Robert K.
 Miho, Katsuge
 Miller, William S.
 Mirikitani, Winston
 Miwa, Colin O.
 Miyagi, Melvyn M.
 Moore, William C.
 Morikawa, Randall I.
 Morry, G. Richard
 Morse, Jack
 Mosley, Roger G.
 Mui, Thomas L.
 Mukaida, Wayne H.
 Myrdal, John R.
 Nagase, Nelson T.
 Nagle, James F.
 Nagle, William J. III
 Nakamoto, Francis M.
 Nakamura, Hideo
 Nakamura, Kenneth H.
 Nakamura, Lee T.
 Nakamura, Richard F.
 Nakamura, Yoshio
 Nakashima, David A.
 Nakashima, Steven M.
 Nakayama, Paula M.
 Neece, Wayne
 Ng, Peter P.J.
 Nip, Ranton
 Nip, Robert L.S.
 Nishida, Rodney S.
 Nishimoto, John S.
 Nishimura, Donald S.
 Noguchi, George K.
 O'Brien, Francis T.
 O'Connor, Michael F.
 Okamoto, Kenneth
 Okimoto, Blake T.
 Oliver, Tamm W.
 Ono, Andrew S.
 Ono, Jeffrey T.
 Ortiz, Jonathan L.
 Oshima, Leighton K.

Pablo, Christopher	Walker, Susan P.
Pacorro, Clarence A.	Watson, Kelli K.
Painter, Eaver W. Jr.	Watts, Thomas
Park, Arthur Y.	Weinberg, Jan
Park, Corey	White, Emmet
Park, Patricia K.	Williams, John R.
Parsons, Wayne D.	Wilson, Michael D.
Paul, James T.	Wisegar, Cynthia
Pavey, Judith Ann	Witherman, Charles H.
Perkins, John F.	Wolff, Peter C. Jr.
Perry, Madelyn L.	Wong, Henry W.C.
Playdon, George W.	Wong, John C.
Pong, Winfred K.T.	Wong, Michael J.Y.
Portnoy, Jeffrey	Wong, Sidney J.Y.
Potts, Dennis W.	Worth, Edgar A.
Price, Warren III	Yamamoto, Myles T.
Rau, Robert E.	Yamamoto, Paul T.
Richards, Robert P.	Yamano, Ernest Y.
Ripley, Arthur Jr.	Yano, Francis H.
Robbins, Kenneth S.	Yano, Vincent H.
Robinson, David M.	Yap, Frank K.L. Jr.
Rosca, Arthur F.	Yampuku, Roy Y.
Roney, John A.	Yomono, Brian K.
Ryan, Joseph A.	Yoshida, Gerald C.
Sakai, Wayne M.	Young, Gregg H.
Sakuda, Bert S.	Yusi, Jennifer M.
Sakurai, Colleen H.	
Schneider, Joseph	
Schulmeister, David	
Schutter, David C.	
Sekiya, Gerald Y.	
Shaughnessy, Patricia L.	
Shigemura, Gary Y.	
Shintani, Randal I.	
Sia, Jeffrey H.K.	
Sieton, Randolph R.	
Snyder, Burt L.	
Stone, James J.	
Stone, Peter T.	
Street, J. Stephen	
Stutenberg, James A.	
Sugimoto, Brian D.	
Sumida, Kevin P.H.	
Sutton, Richard C. Jr.	
Suzuki, Norman	
Tan, Raymond J.	
Taylor, Jeffrey M.	
Terance, Janice h.	
Tharp, James W.	
Thomas, Juan D. Jr.	
Thomas, Mark A.	
Togioka, Leslie C.	
Tom, Herbert K.	
Tom, Michael D.	
Tom, Stephen D.	
Tomas, Paul A.	
Toyokuni, Robert S.	
Trecker, Steven J.	
Tsukiyama, Ted T.	
Tumacher, John	
Turbin, Richard	
Turk, David L.	
Ukishima, Daniel S.	
Van Etten, Alan	
Wei, Louis K.	

IX. SECOND, THIRD, AND FIFTH CIRCUIT ARBITRATORS

Second Circuit

Albrechtson, Al
 Bana, Armando C.
 Brumbaugh, James P.
 Callahan, Michael J.
 Cardozo, Joseph E.
 Chasburn, Lowell
 Clair, John G. Jr.
 Cole, Thomas R.
 D'Ambeau, Madelyn S.
 Dombroski, James M.
 Fleming, William L.
 Foster-Au, Renata
 Fukusaka, Ken R.
 Fukushima, Howard M.
 Garcia, Stephen G.
 Goldsmith, Stephen E.
 Hall, Vick J.
 Haywood, Guy A.
 Higa, Kase
 Ho, Diane
 Kohne, William L.
 Koller, Lillian S.
 Langa, Sanford J.
 Leuteneker, Tom C.
 Luna, S. Martin
 MacDonald, Barclay E.
 Macrae, Edward P.
 McNulty, Deborah
 McNulty, Tim
 Nakamura, Craig G.
 Nakamura, David H.
 Niles, Dennis J.
 Ogile, William F.
 Priest, Richard A. Jr.
 Ramil, Antonio V.
 Ranken, Anthony L.
 Robert, Gary
 Rowland, Robert E.
 Shimoda, Walter
 Takaouki, Anne M.
 Takayasu, James S.
 Tam, John F.
 Tateishi, Michael K.
 Tengan, Davelynn M.
 Thomas, Jack T.
 Ueoka, Meyer M.
 Ueoka, Paul M.
 Walton, Everett

Third Circuit

Altman, Gary
 Amato, Donald M.
 Amato, Riki May
 Bartsch, Richard P.
 Bethen, Robert E.
 Brown, Karen Mayan
 Burgess, John M.A.
 Carlsmith, Donn W.
 Chock, Nolan K.C.
 Choi, Jeffrey
 Chung, Clayton E.
 Chong, Curtis E.
 Choy, Duane D.
 Christensen, Steven K.
 Clay, James C.
 Cohn, Lawrence W.
 Cook, Valen A.
 Cornell, Craig S.
 Cox, Victor M.
 Crudele, Robert J.
 Dabney, Michael
 daSilva, Tim E.
 Dixon, Steven B.
 Dnt, Nelson R.
 Fagundes, Joseph M. III
 Fukuhara, Calvin J.
 Gaudin, Ben H.
 Gallup, Wallace M. Jr.
 Giennini, Frederick D.O.
 Halsted, Douglas L.
 Manohano, Peter
 Hara, Gilbert K.
 Hara, Glenn G.
 Hara, Michael E.
 Hasegawa, Geraldine N.
 Hasegawa, Raymond K.
 Hastings, Robert W. II
 Henricks, Arne T.
 Ibarra, Ronald
 Ing, Wendell Y.Y.
 Ireijo, James S.
 Ishado, Lester J.
 Ishida, Richard T.
 Iwashita, Andrew S.
 Jolly, William E.
 Kimura, Glenn N.
 Kimura, Jay T.
 Kimura, Keigo
 Kitaka, Carol S.W.
 Kunimura, Ruth A.
 Kushi, Herbert I.
 Lau, Robert I.W.
 Lee, Anson K.
 Leitel, Ira
 Leithaad, Arthur S.
 Lenell, Meredith
 Lim, Steven
 Love, Colin L.
 Lui-Kuan, Timothy
 Martin, Donald K.
 Marx, Robert P.
 Matsukawa, Michael J.
 McCarthy, William J. Jr.
 McIntosh, James L.
 Medeiros, Michael J.
 Meneses, Stephen J.
 Metcalf, Wayne C. III
 Meyer, Lionel D.
 Miller, Frank L. IV
 Mischak, E. S.

Fifth Circuit

Blake, Hartwell H.K.
 Boschard, Kurt R.
 Budd, Nancy J.
 Chihara, Ted A.
 Dobashi, Daryl Y.
 Duvauchelle, Raymond C.
 Esaki, Amy I.
 Feldhacker, William
 Grinpas, Robert M.
 Hong, Walton D.Y.
 Jung, James G. Jr.
 Kahr, E. Courtenay
 Komori, Arthur S.
 Licks, James W.
 Masuoka, George M.
 McCreery, Lawrence D.
 Murashige, Calvin E.
 Nii, Michael M.
 Perry, Warren C.R.
 Shimizu, Wayne S.
 Shiraishi, Clinton I.
 Shiraishi, Sherman T.
 Trask, Arthur K. Jr.
 Watanabe, Kathleen M.A.
 Wilson, Donald H.
 Yamada, Dennis R.

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The National Institute for Dispute Resolution (NIDR) is a private, non-profit foundation that provides support and technical assistance in the field of ADR. NIDR provided early, consultative and financial help to the Judiciary during the CAP's start-up.

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COURT ANNEXED ARBITRATION PROGRAM

FIRST CIRCUIT COURT

FEBRUARY 15, 1986 through DECEMBER 31, 1988

REPORT DATE - JANUARY 25, 1989

	<u>* OLD RULES</u>	<u>** NEW RULES</u>	<u>TOTAL</u>
TOTAL CASES RECEIVED IN THE PROGRAM - - - -	278	1,297	1,575
CASES TERMINATED			
SETTLEMENTS - - - - -	186	378	564
AWARDS - - - - -	65	139	204
DISMISSED - - - - -	20	134	154
OTHERS - - - - -	6	60	66
REQUEST TO EXEMPT GRANTED - - - - -	N/A	62	62
TOTAL CASES TERMINATED - - - - -	277	773	1,050
TOTAL PENDING CASES - - - - -	1	524	525
AWARDS			
ISSUED - - - - -	66	151	217
APPEALED - - - - -	27	83	110
APPEALS SETTLED - - - - -	21	29	50
REQUEST TO EXEMPT CASES			
TOTAL FILED - - - - -	N/A	455	455
GRANTED - - - - -	N/A	336	336
DENIED - - - - -	N/A	46	46
DENIED, ASSIGNED TO COMPARISON GROUP -	N/A	73	73

* - OLD RULES (2/15/86 through 4/30/87)

** - NEW RULES (5/1/87 - effective date)

EXHIBIT A

HAWAII ARBITRATION RULES

(Rules Governing the Court Annexed Arbitration Program)

**Appended to the Rules of the Circuit Courts of the State of Hawaii as
Exhibit A pursuant to Circuit Court Rule 34, added January 22, 1986**

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Release 87-4, May 1987

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HAWAII ARBITRATION RULES**Rule 1. THE COURT ANNEXED ARBITRATION PROGRAM**

The Court Annexed Arbitration Program (the Program) is a mandatory, non-binding arbitration program, as hereinafter described, for certain civil cases in the State of Hawaii.

Rule 2. INTENT OF PROGRAM AND APPLICATION OF RULES

(A) The purpose of the Program is to provide a simplified procedure for obtaining a prompt and equitable resolution of certain civil matters to be designated by the Judicial Arbitration Commission.

(B) These rules shall not be applicable to arbitration by private agreement or to other forms of arbitration under existing statutes, policies and procedures.

(C) These arbitration rules are not intended, nor should they be construed, to address every issue which may arise during the arbitration process. The intent of these rules is to give considerable discretion to the arbitrator, the Arbitration Administrator and the Judicial Arbitration Commission. Arbitration hearings are intended to be informal, expeditious and consistent with the purposes and intent of these rules.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 3. THE ARBITRATION JUDGE

(A) The Arbitration Judge for the Program shall be a Circuit Court Judge who shall be appointed by the Chief Justice.

(B) The Arbitration Judge shall determine all disputed issues under these rules as hereinafter set forth, including, but not limited to, all disputed issues concerning the arbitrability of cases and the qualifications and acts of arbitrators.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 4. THE JUDICIAL ARBITRATION COMMISSION

(A) The Chief Justice shall establish a Judicial Arbitration Commission which will have the responsibility to develop, monitor, maintain, supervise and evaluate the Program for the State of Hawaii.

(B) The Judicial Arbitration Commission shall include a chair-

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person who shall be the Arbitration Judge, and a representative to be designated by the President of the Hawaii State Bar Association. Additional members shall be appointed at the discretion of the Chief Justice.

(C) The Judicial Arbitration Commission shall be responsible for the selection and training of arbitrators.

(D) The Judicial Arbitration Commission shall be responsible for the hiring, supervision and evaluation of the Arbitration Administrator and all additional necessary staff.

(E) The Judicial Arbitration Commission shall interpret these rules prior to the appointment of an arbitrator in any case under the Program.

(F) The Judicial Arbitration Commission may promulgate rules and regulations necessary to fulfill its responsibilities under these rules.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 5. THE ARBITRATION ADMINISTRATOR

The Arbitration Administrator shall be appointed by the Judicial Arbitration Commission and shall be responsible for the operation and management of the Program, as hereinafter set forth.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 6. MATTERS SUBJECT TO ARBITRATION

(A) All tort cases, including appeals or transfers from district courts, having a probable jury award value, not reduced by the issue of liability and not in excess of One Hundred Fifty Thousand Dollars (\$150,000.00), exclusive of interest and costs, may be accepted into the Program at the discretion of the Judicial Arbitration Commission.

(B) Any other civil case, regardless of the monetary value or the amount in controversy, may be submitted to the Program upon the agreement of all parties and the approval of the Arbitration Judge.

(C) Parties to cases submitted or ordered to the Program may agree at any time to be bound by any arbitration ruling or award.

(D) The Arbitration Judge may accept into, or remove from, the Program any action where good cause for acceptance or removal is found. The Court's decision in this regard is non-reviewable.

(Amended April 16, 1987, effective May 1, 1987.)

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Rule 7. RELATIONSHIP TO CIRCUIT COURT JURISDICTION AND RULES; FORM OF DOCUMENTS

(A) Cases filed in, or removed to, the Circuit Court shall remain under the jurisdiction of that court for all phases of the proceedings, including arbitration.

(B) Except for the authority to act or interpret these rules expressly given to the arbitrator, the Arbitration Administrator, the Judicial Arbitration Commission, or the Arbitration Judge, all issues shall be determined by the Circuit Court with jurisdiction.

(C) Before a case is submitted or ordered to the Program, and after a Notice of Appeal and Request for Trial *De Novo* is filed, all applicable rules of the Circuit Court and of civil procedure apply. After a case is submitted or ordered to the Program, and before a Notice of Appeal and Request for Trial *De Novo* is filed, or until the case is removed from the Program, these rules apply.

(D) The calculation of time and the requirements of service of pleadings and documents under these rules shall be the same as under the Hawaii Rules of Civil Procedure.

(E) Circuit Court Rule 12(a)(17), and all rules of court or of civil procedure requiring the filing of pleadings, remain in effect notwithstanding the fact that a case is under the Program.

(F) All dispositive motions shall be made to the Circuit Court as required by law or rule notwithstanding the fact that a case is under the Program.

(G) All documents required to be utilized or filed under these rules shall be in a form designated by the Arbitration Judge.

(H) Once a case is submitted or ordered to the Program all parties subsequently joined in the action shall be parties to the arbitration unless dismissed by the Arbitration Judge.

Rule 8. DETERMINATION OF ARBITRABILITY

(A) The court shall view all tort cases as arbitration eligible and automatically "in" the Program unless plaintiff certifies that his or her case has a value in excess of the jurisdictional amount of the Program which is \$150,000. Plaintiff shall file a request for exemption at the time of filing and such a request shall include a summary of facts which support plaintiff's contentions.

(B) Where exemptions from arbitration have been requested, the Arbitration Administrator shall review the contentions, facts and

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evidence available and determine eligibility. The Arbitration Administrator may upon request require that a party submit additional facts which support the party's contentions. Any objection(s) to his decision must be filed with the Arbitration Judge within ten (10) days from the date the decision is served, with service to opposing counsel.

(C) Subsequent to the filing of the complaint, any party who believes a case should be removed from or readmitted to the Program, shall file a request to remove or readmit, with the Arbitration Judge. Such a request shall include a summary of the facts which support their contentions, with service to opposing party.

(D) The Arbitration Judge shall make all final determinations regarding the arbitrability of a case when that issue is disputed by any party, and may hold a conference on the issue of arbitrability at his discretion.

(E) The Arbitration Judge may, at his discretion, impose sanctions of reasonable costs and attorney's fees against any party who without good cause or justification attempts to remove a case from the Program.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 9. ASSIGNMENT TO ARBITRATOR

(A) Parties may select and stipulate to a private arbitrator(s), who is an arbitrator not on the panel of the Program, or one who is on the panel but who has agreed to serve on a private basis. Such stipulation must be made within twenty (20) days after the appearance of defense counsel and must include a statement signed by the arbitrator(s) expressing his or her express willingness to arbitrate under the rules and procedures of the Court Annexed Arbitration Program and a duly signed arbitrator's oath.

(B) Any and all fees or expenses related to the use of a private arbitrator(s) shall be borne by the parties.

(C) Unless the Arbitration Administrator is notified of a stipulation for a private arbitrator(s) within the above twenty (20) day period, the Arbitration Administrator will then serve the parties with identical lists of five (5) arbitrators.

(1) Thereafter, each party shall, within ten (10) days, return the list with no more than two (2) names stricken.

(2) If both parties respond, the Arbitration Administrator shall appoint an arbitrator from among those names not stricken.

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(3) If only one party responds within the ten (10) day period, the Arbitration Administrator shall appoint an arbitrator from among those names not stricken.

(4) If neither party responds within the ten (10) day period, the Arbitration Administrator will appoint one of the five (5) arbitrators.

(D) If there are more than two (2) adverse parties, at least two (2) additional arbitrators per each additional party shall be added to the list with the above method of selection to apply.

(E) Where an arbitrator is assigned to a case and subsequent thereto, additional party(s) are added, said party(s) may object to the arbitrator assigned to the case within ten (10) days from the party(s)' appearance. Objection(s) must be in writing stating specific grounds and filed with the Arbitration Administrator, who will review the objection(s) and render a decision. This decision may be appealed to the Arbitration Judge.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 10. QUALIFICATIONS OF ARBITRATORS

(A) The Judicial Arbitration Commission shall create and maintain a panel of arbitrators consisting of attorneys licensed to practice in the State of Hawaii and, in its discretion, qualified non-attorneys.

(B) Attorneys serving as arbitrators shall have substantial experience in civil litigation, and shall have been licensed to practice law in the State of Hawaii for a period of five (5) years, or can provide the Judicial Arbitration Commission with proof of equivalent qualifying experience.

(C) Arbitrators shall be required to complete an orientation and training program following their selection to the panel and other additional training sessions or classes scheduled by the Judicial Arbitration Commission or Arbitration Administrator.

(D) Arbitrators shall be sworn or affirmed by the Chief Justice or his designee to uphold these rules of the Program, the laws of the State of Hawaii, and the Code of Ethics of the American Arbitration Association.

(E) An arbitrator who would be disqualified for any reason that would disqualify a judge under the Code of Judicial Conduct shall immediately resign or be withdrawn as an arbitrator.

(F) Any issue concerning the disqualification of an arbitrator shall be referred to the Judicial Arbitration Commission for a final.

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non-reviewable determination.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 11. AUTHORITY OF ARBITRATORS

(A) Arbitrators shall have the general powers of a court and may hear cases in accordance with established rules of evidence and procedure, liberally construed to promote justice and the expeditious resolution of disputes. These include, but are not limited to, the power:

- (1) To administer oaths or affirmations to witnesses;
- (2) To relax all applicable rules of evidence and procedure to effectuate a speedy and economical resolution of the case without sacrificing a party's right to a full and fair hearing on the merits;
- (3) To decide procedural issues arising before or during the arbitration hearing, except issues relating to his or her qualifications as an arbitrator;
- (4) To invite or order, with reasonable notice, the parties to submit pre-hearing or post-hearing briefs;
- (5) To examine, after notice to the parties, any site or object relevant to the case;
- (6) To issue subpoenas for the attendance of witnesses or production of documentary evidence;
- (7) To determine the place, time and procedure to hear all matters;
- (8) To interpret these rules in all proceedings before him or her;
- (9) To find witnesses or parties in contempt and to impose sanctions as provided by the laws of the State of Hawaii; and
- (10) To attempt, with the consent of all parties in writing, to aid in the settlement of the case.

(B) Any challenge to the authority or the act of an arbitrator shall be made to the Arbitration Administrator who will make a ruling on the issue in due course. An appeal from the ruling of the Arbitration Administrator may be made within ten (10) days from the date of said ruling to the Arbitration Judge, who shall have the non-reviewable power to uphold, overturn or modify the ruling of the Arbitration Administrator, including the power to stay any proceeding.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 12. STIPULATIONS

Any stipulation between the parties relating to the conduct of the

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arbitration proceeding, or any factual matter therein, shall be in writing and signed by the counsel or parties, and filed with the arbitrator.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 13. RESTRICTIONS ON COMMUNICATIONS

(A) Neither counsel nor parties may communicate directly with the arbitrator regarding the merits of the case, except in the presence of, or with reasonable notice to, all of the other parties.

(B) No disclosure of any offer or demand of settlement made by any party shall be made to the arbitrator prior to the filing of an award without the agreement of all other parties.

Rule 14. DISCOVERY

(A) Once a case is submitted or ordered to the Program, the extent to which discovery is allowed, if at all, is at the sole discretion of the arbitrator. Types of discovery shall be those permitted by the Hawaii Rules of Civil Procedure, but these may be modified in the discretion of the arbitrator to save time and expense.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 15. SCHEDULING OF HEARINGS: PRE-HEARING CONFERENCES

(A) All arbitrations shall take place and all awards filed no later than nine (9) months from the date of service of the complaint to all defendants, or the Order of Arbitration by the Arbitration Judge, unless said time is modified by the Arbitration Judge pursuant to this rule. Arbitrators shall set the time and date of the hearing within this period.

(B) The arbitration date may be advanced or continued upon petition for good cause to the arbitrator. Petition to the Arbitration Judge must be made for a continuance beyond the above nine (9) month period.

(C) Consolidated actions shall be heard on the date assigned to the latest case involved.

(D) Arbitrators and or the Arbitration Administrator may, at their discretion, conduct pre-arbitration hearings or conferences. However, arbitrators must schedule a pre-hearing conference within thirty (30) days from the date a case is assigned.

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(E) Counsel shall give immediate written notification to the Arbitration Administrator of any change of the arbitration date, any settlement or changes of counsel.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 16. PREHEARING STATEMENT

(A) At least thirty (30) days prior to the date of the arbitration hearing, each party shall file with the arbitrator and serve upon all other parties a statement containing a list of probable witnesses whom the party intends to call at the arbitration hearing and a list of exhibits and documentary evidence anticipated to be introduced. The statement shall contain a brief description of the matters about which each witness will be called to testify. Each party, upon request, shall make all exhibits and documentary evidence available for inspection and copying by other parties at least twenty (20) days prior to the hearing date.

(B) A party failing to comply with this rule, or failing to comply with any discovery order, may not present at the hearing a witness or exhibit required to be disclosed or made available, except with the permission of the arbitrator.

(C) Each party shall furnish the arbitrator at least twenty (20) days prior to the arbitration hearing copies of any pleadings and other documents contained in the court file which that party deems relevant.

Rule 17. CONDUCT OF THE HEARING

(A) The arbitrator shall have complete discretion over the mode and order of presenting evidence and the conduct of the hearing.

(B) No transcription or recording shall be permitted of the arbitration proceedings.

(Amended April 16, 1987, effective May 1, 1987.)

Rule 18. ARBITRATION IN THE ABSENCE OF A PARTY

An arbitration may proceed in the absence of any party who, after due notice, fails to be present or fails to obtain a continuance. The arbitrator shall require the party present to submit such evidence as he or she may require for the making of an award, and may offer the absent party an opportunity to appear at a subsequent hearing.

Arbitration Rules

Rule 21

Rule 19. FORM AND CONTENT OF AWARD

(A) Awards by the arbitrator shall be in writing, signed and on forms prescribed by the Arbitration Judge.

(B) The arbitrator shall determine all issues raised by the pleadings that are subject to arbitration under the Program, including a determination of comparative negligence, if any, damages, if any, and costs. The amount of damages that can be awarded is not limited to the jurisdictional amount for arbitration.

(C) Findings of Fact and Conclusions of Law are not required.

(D) After an award is made, the arbitrator shall return all exhibits to the parties who offered them during the hearing.

Rule 20. FILING OF AWARD

(A) Within seven (7) days after the conclusion of the arbitration hearing, or thirty (30) days after the receipt of the final authorized memoranda of counsel, the arbitrator shall file the award with the Arbitration Administrator, who shall then serve copies of said award to the attorneys of record. Application by the arbitrator to the Arbitration Administrator must be made for an extension of these time periods.

(B) The arbitrator may file with the Arbitration Administrator an amended award to correct an obvious error in the award if done within the seven day period for filing an award. Subsequent to this time, application must be made to the Arbitration Administrator. Any amended award shall be served upon the attorneys of record by the Arbitration Administrator.

(C) This rule does not authorize the use of an amended award to change the arbitrator's decision on the merits. An amended award may only modify an award in order to correct an inadvertent miscalculation or description, or to adjust the award in a matter of form rather than substance. Any modification of substance can only be made upon application to the Arbitration Judge.

(Amended April 16, 1987, effective May 1, 1987)

Rule 21. JUDGMENT ON AWARD

If, after twenty (20) days after the award is served upon the parties, no party has filed a written Notice of Appeal and Request for Trial *De Novo*, the clerk of the court shall, upon notification by the Arbitration Administrator, enter the arbitration award as a final judgment of the

Rule 21

court. Said award shall have the same force and effect as a final judgment of the court in the civil action, but may not be appealed.

(Amended April 16, 1987, effective May 1, 1987)

Rule 22. REQUEST FOR TRIAL DE NOVO

(A) Within twenty (20) days after the award is served upon the parties, any party may file with the clerk of the court and serve on the other parties and the Arbitration Administrator a written Notice of Appeal and Request for Trial *De Novo* of the action.

(B) After the filing and service of the written Notice of Appeal and Request for Trial *De Novo*, the case shall be set for trial pursuant to applicable court rules.

(C) If the action is triable by right to a jury, and a jury was not originally demanded but is demanded within ten (10) days of service of the Notice of Appeal and Request for Trial *De Novo* by a party having the right of trial by jury, the trial *de novo* shall include a jury, and a jury trial fee shall be paid as provided by law.

Rule 23. PROCEDURES AT TRIAL DE NOVO

(A) The clerk shall seal any arbitration award if a trial *de novo* is requested. The jury will not be informed of the arbitration proceeding, the award, or about any other aspect of the arbitration proceeding. The sealed arbitration award shall not be opened until after the verdict is received and filed in a jury trial, or until after the judge has rendered a decision in a court trial.

(B) All discovery permitted during the course of the arbitration proceedings shall be admissible in the trial *de novo* subject to all applicable rules of civil procedure and evidence. The court in the trial *de novo* shall insure that any reference to the arbitration proceeding is omitted from any discovery taken therein and sought to be introduced at the trial *de novo*.

(C) No statements or testimony made in the course of the arbitration hearing shall be admissible in evidence for any purpose in the trial *de novo*.

Rule 24. SCHEDULING OF THE TRIAL DE NOVO

Every case transferred to the Program shall maintain the approximate position on the civil trial docket as if the case had not been so transferred, unless at the discretion of the court, the docket position is modified.

Arbitration Rules

Rule 27

Rule 25. THE PREVAILING PARTY IN THE TRIAL DE NOVO; COSTS

(A) The "Prevailing Party" in a trial *de novo* is the party who has (1) appealed and improved upon the arbitration award by 15% or more, or (2) has not appealed and the opposing party has appealed and failed to improve upon the arbitration award by 15% or more. For the purpose of this rule, "improve" or "improved" means to increase the award for a plaintiff or to decrease the award for the defendant.

(B) The "Prevailing Party" under these rules, as defined above, is deemed the prevailing party under any statute or rule of court, and as such is entitled to costs of trial and all other remedies as provided by law.

Rule 26. SANCTIONS FOR FAILING TO PREVAIL IN THE TRIAL DE NOVO

(A) After the verdict is received and filed, or the court's decision rendered in a trial *de novo*, the trial court may, in its discretion, impose sanctions, as set forth below, against the non-prevailing party whose appeal resulted in the trial *de novo*.

(B) The sanctions available to the court are as follows:

- (1) Reasonable costs and fees (other than attorneys' fees) actually incurred by the party but not otherwise taxable under the law;
- (2) Costs of Jurors;
- (3) Attorneys' fees not to exceed \$5,000;

(C) Sanctions imposed against a plaintiff will be deducted from any award rendered. Sanctions imposed against a defendant will be added to any award rendered.

(D) In determining sanctions, if any, the court shall consider all the facts and circumstances of the case and the intent and purpose of the Program in the State of Hawaii.

Rule 27. EFFECTIVE DATE

These rules become effective as of February 15, 1986 and shall apply to all cases filed thereafter; provided that the rules governing the creation and organization of the Program and Commission shall be effective immediately.

THE COURT ANNEXED ARBITRATION PROGRAM:

JANUARY 1989 EVALUATION REPORT

Professor Gene Kassebaum*

Professor John Barkai**

Professor David Chandler***

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EXECUTIVE SUMMARY

THE COURT ANNEXED ARBITRATION PROGRAM: JANUARY 1989 EVALUATION REPORT

Professors Gene Kassebaum, John Barkai, and David Chandler

During the past few years, virtually all state and federal jurisdictions have considered various alternative dispute resolution (ADR) methods to treat the major problems with their court systems: high costs and excessive delay. Court-annexed arbitration is one of the most popular innovations. Programs are currently operating in at least twenty states and ten United States Federal District Courts.

In 1986, Hawaii's Court Annexed Arbitration Program (CAAP) was introduced to "provide a simplified procedure for obtaining a prompt and equitable resolution of certain civil matters." Hawaii Arbitration Rule 2(A). Since May 1987 this experimental program has been a mandatory, non-binding arbitration procedure for tort cases with a probable jury award of \$150,000 or less. At this jurisdictional level, approximately 1500 tort cases per year are eligible for the program across the state.

The major goals of the program are: 1) to reduce litigant costs; 2) to increase the pace of disposing of cases; and 3) to maintain, if not improve, litigant satisfaction with Hawaii's civil justice system. Over 400 experienced lawyers are the volunteer arbitrators in this program. They are the key to implementing the program goals. An arbitrator is chosen by the lawyers in the case from a panel of five proposed arbitrators. The arbitrator then works with the attorneys to: 1) eliminate unnecessary pretrial discovery; 2) encourage and facilitate early settlement; and 3) manage the pace of case activity. In the minority of cases where settlement does not occur the arbitrator then; 4) holds a hearing in which litigants have a low cost opportunity for their "day-in-court"; and 5) renders an award. If the award is not accepted, the case returns to the ordinary litigation track for a trial de novo.

There is considerable national interest in Hawaii's Court Annexed Arbitration Program because it has several unique features. Hawaii is the only state which attempts to limit pretrial discovery in order to reduce litigant costs; Hawaii has the highest dollar ceiling (\$150,000) among states that offer full arbitration hearings; Hawaii has the only state-wide arbitration program.

Researchers from the University of Hawaii are evaluating this experimental program in the First Circuit where approximately 1000 tort cases per year are eligible for the

program. The primary sources of empirical information in the research are over 1000 questionnaires of lawyers and arbitrators, and data bases from the arbitration program and the court. The evaluation design randomly assigns one half of the eligible cases to arbitration and the other half to a comparison group that goes through regular litigation. Only a small proportion of cases in the comparison group have terminated so they can not yet be used in the evaluation analysis.

Since the program began in 1986, more than 1500 cases have entered CAAP. The majority of cases settle in CAAP and do not result in an arbitration hearing. The ratio of settlements to awards is about 3 to 1. Just over 50 percent of the awards are appealed, but so far virtually all of the appeals have resulted in settlements on appeal. Only one of the over 750 cases that have terminated after entering CAAP has ended in a trial.

INCREASING THE PACE OF LITIGATION

Approximately three quarters of the CAAP cases close within the program requirement of nine months from the defendant's answer, but delays in assigning an arbitrator have resulted in a significant proportion of cases exceeding the nine month limit. The time to assign an arbitrator currently averages 67 days. The Judicial Arbitration Commission and the Arbitration Administrator are taking steps to rectify this delay. Nonetheless, most of the cases in CAAP close within one year from the answer by the defendant. Once arbitrators are assigned to a case, the cases progress at a timely pace. 60 percent of settlements and 38 percent of awards occur within six months, and only about 10 percent of the cases remain open nine months after the arbitrator is assigned.

In November 1988, a "general survey" was sent to the 91 lawyers (an almost equal number of plaintiff and defense lawyers) who handled the greatest number of arbitration cases among the cases we surveyed. These 91 lawyers were involved in 84 percent of the cases we surveyed, and many of them also were arbitrators. Although this general survey did not ask about specific cases, it does represent the general opinions of the lawyers who are the most active in the program. 92 percent of these "frequent flyers" thought that most CAAP cases were faster than cases in regular litigation.

Compared to other states, delay due to slow pretrial case processing is not a major problem in Hawaii's courts. Since CAAP appears to be increasing the pace of litigation, a backlog of cases should not develop, and there should be prompt access to the courts for litigants whose cases require a trial.

SATISFACTION

The great majority of both plaintiffs' and defense lawyers reported that they were satisfied with how their specific case was handled in CAAP. Defense lawyers were somewhat less satisfied than were plaintiffs' lawyers. As might be expected, there is more dissatisfaction about awards than about settlements.

In the general survey, 67 percent of the lawyers reported that they were satisfied with the program and 28 percent were dissatisfied. A major difference in satisfaction is found between plaintiffs' and defense lawyers. 91 percent of plaintiffs' lawyers reported being satisfied, but only 46 percent of the defense lawyers reported being satisfied. The reason for the dissatisfaction by the defense lawyers is not clear. Certainly one hypothesis for defense dissatisfaction would be that defense lawyers may be making less money on CAAP cases because limitations on pretrial discovery result in fewer billable hours for the lawyers. We do know from the general survey that defense dissatisfaction is correlated to the opinion that the value of cases has increased.

REDUCING LITIGANT COSTS

The reduction of pretrial discovery is a chief feature of CAAP, and it is the feature which is expected to produce lower litigant costs. The majority of lawyers and arbitrators report that discovery was reduced in arbitrated cases. However, a significant minority of lawyers think that discovery limitation may have affected or did affect the outcome of their case.

Until more comparison cases close and we have cost data from them, we cannot say how much the program is actually reducing costs, and we cannot even confirm that it is reducing costs. However, in the general survey, 83 percent of the lawyers thought that most cases in CAAP were completed at lower cost. A few lawyers thought CAAP cost about the same amount, but not a single lawyer thought CAAP was more expensive in most cases.

We do have data on the cost of discovery for CAAP cases. The average discovery costs for each side in the litigation are about \$400 for cases that settle and about \$900 for cases that go to an arbitration award. These costs do not include the defense lawyers' fees for the time spent conducting the discovery.

Of course discovery costs are just part of total litigant costs. The largest part of litigant costs are lawyers' fees, not the discovery costs. Because plaintiffs' lawyers work on a contingent fee arrangement and defense lawyers work on an hourly fee arrangement, a reduction in discovery will not reduce the plaintiffs' lawyers fees but should reduce the defense lawyers

fees. A reduction of discovery costs therefore will reduce total litigation costs more for defendants than it will for plaintiffs.

Assuming that 1500 cases are eligible for CAAP state-wide each year, then for every \$100 that the program can reduce litigation costs per case, total litigation costs would be reduced \$150,000 annually in Hawaii. In addition to the direct cost savings for litigants, there also may savings for the state if judges and court clerks spend less time processing tort cases.

ARBITRATORS, CASES & HEARINGS

Almost all lawyers report that the arbitrators were experienced enough to handle the cases and were impartial. Arbitrators averaged less than 5 hours of work on settlements and about 15 hours on cases in which awards were rendered.

The average case is settled or results in an award of about \$30,000; awards are averaging about 10 percent higher than settlements. Even with a \$150,000 limit, almost 90 percent of the cases have settlements or awards of \$50,000 or less. Very few cases are considered to be complex by the lawyers.

Accelerated pace and cost containment in CAAP does not prevent litigants from having their "day in court." Plaintiffs testified at virtually all arbitration hearings; defendants testified at the majority of hearings. However, expert testimony was presented in only one-third of the cases. Low levels of expert testimony may represent an important cost saving in CAAP as well as resulting in less inconvenience for doctors and other professionals.

IMPORTANT PROGRAM ISSUES

The issues of arbitrator quality, compensation, and supply, merit special discussion. First, despite informal comments that some of the arbitrators may not be qualified, the overwhelming weight of survey evidence indicates that arbitrators in CAAP were both impartial and experienced enough to handle the cases. Second, thoughts of providing any compensation to the arbitrators must be carefully analyzed. Payment might be justified based upon either an analysis of the economic benefits of the program or a theory of arbitrator motivation. However, any honorarium or stipend is an added cost of the program, and such a payment might offset any cost savings that CAAP achieved. Finally, the capacity of the program is a significant concern. With the current supply of arbitrators and operating assumptions, the program appears to be operating at maximum capacity even though it is only handling one-half of the tort cases in the state. The Judicial Arbitration Commission is working on this problem.

Hawaii's Court Annexed Arbitration Program appears to be meeting its goals of reducing litigant costs, increasing pace, and maintaining the satisfaction of the participants. Although it does not appear that CAAP could handle all the tort cases filed in Hawaii courts under its current operating procedures, the Judicial Arbitration Commission is working on this problem.

CAAP is delivering arbitration largely within the time frame prescribed by its rules, and is doing so to the satisfaction of the majority of lawyers. It clearly has succeeded in reducing pretrial discovery, and no other program can make that claim. After more comparison cases have closed, a later report will be able to provide data comparing pace, cost, and satisfaction in CAAP with regular litigation. To our knowledge, no other arbitration program in country claims to be reducing litigation costs; Hawaii leads the nation in this area.

**THE COURT ANNEXED ARBITRATION PROGRAM:
JANUARY 1989 EVALUATION REPORT**

PROGRAM HISTORY

During the past few years, virtually all state and federal jurisdictions have considered various alternative dispute resolution (ADR) methods to treat the major problems with their court systems: high costs and excessive delay. Court-annexed arbitration is one of the most popular innovations. Programs are currently operating in at least twenty states and ten United States Federal District Courts.

In 1986, Hawaii's Court Annexed Arbitration Program (CAAP) was introduced to "provide a simplified procedure for obtaining a prompt and equitable resolution of certain civil matters." Hawaii Arbitration Rule 2(A). Since May 1987 this experimental program has been a mandatory, non-binding arbitration procedure for tort cases with a probable jury award of \$150,000 or less. At this jurisdictional level, approximately 1500 tort cases per year are eligible for the program across the state.

The major goals of the program are: 1) to reduce litigant costs; 2) to increase the pace of disposing of cases; and 3) to maintain, if not improve, litigant satisfaction with Hawaii's civil justice system. CAAP seeks to achieve these goals by eliminating unnecessary pretrial discovery and controlling the pace of cases. In addition, the program attempts to stimulate early settlement, and yet offers litigants a low cost "day-in-court" in the form of an arbitration hearing. Litigants who are not satisfied with the arbitration award may "appeal" their case and put it into regular litigation.

A considerable amount of national attention has been directed to Hawaii's Court-Annexed Arbitration Program because our program is unique in several respects. The program has the highest dollar ceiling (\$150,000) of any mandatory state arbitration program in the country and it is the only state-wide program. Most importantly, it appears to be the only program making a major effort to limit pretrial discovery, and as such it offers the greatest potential for reducing litigant costs.

The CAAP has operated in two different forms. Phase I began in February 1986, and was a voluntary program for cases valued at \$50,000 or less. Phase II began in May 1987, and is a mandatory program for cases valued up to \$150,000. The current \$150,000 program is referred to as Phase II. All data presented in this report will refer only to Phase II unless otherwise noted.

PROGRAM DESCRIPTION

Since May 1, 1987, when Phase II began, all tort cases are initially assigned to the arbitration program, and then attorneys must request that their case be exempted from the program if they believe the value of their case exceeds \$150,000. After the defendant's answer is filed (or the last defendant's answer if there are multiple defendants), a volunteer arbitrator is assigned to the case. The arbitrator must schedule a pre-hearing conference within 30 days from the date a case is assigned and determine what pretrial discovery will be allowed. Discovery is only permitted with the consent of the arbitrator. The arbitrator can attempt to aid in the settlement of the case if all parties consent in writing. If the case precedes to an arbitration hearing, attorneys must file a pre-hearing statement 30 days prior to the hearing.

Over 400 lawyers now serve the program as volunteer arbitrators. They are selected from lawyers who have at least 5 years of experience and most of them practice personal injury litigation. After a short, group orientation, the new volunteers are added to the pool of arbitrators. Their names are placed randomly in 5 person panels for each case. Each lawyer may strike two names ensuring that at least one arbitrator is chosen for each case.

At the arbitration hearing, the rules of evidence can be relaxed and no transcription or recording is permitted. Arbitration awards must be in writing although findings of fact and conclusions of law are not required. Awards are not limited to the jurisdictional amount of \$150,000. Awards must be filed within seven days of the conclusion of the arbitration hearing or within thirty days after the receipt of the final authorized memoranda of counsel. The award becomes the final judgment if no party files a written Notice of Appeal and Request for Trial De Novo within 20 days after the award is served upon the parties.

If such Notice of Appeal and Request for Trial De Novo is timely filed, the case is scheduled for trial de novo.¹ The case is then treated as if it never had been in arbitration and full discovery is permitted under the rules of civil procedure. However, no testimony made during the course of the arbitration hearing is admissible in the trial de novo. There are disincentives attached to the appeal process in the form of sanctions for failure to prevail in the trial de novo. When parties appeal, they must do at least 15 percent better at the

¹. In the almost three years that CAAP has been in operation, only one case has actually resulted in a trial de novo. All other appeals have either settled before trial or remain pending.

trial de novo than they did at the arbitration award or be subject to sanctions of attorney fees up to \$5000, costs of jurors, and other reasonable costs actually incurred.

THE EVALUATION PROCEDURE

Researchers from the University of Hawaii are evaluating the program in the First Circuit, where approximately 1000 tort cases per year are eligible for the program. Information for the evaluation comes primarily from surveys of lawyers and the case record database of the Arbitration Administrator. The evaluation design randomly assigns one-half of the eligible cases to arbitration and the other half are assigned to a comparison group that goes through the regular litigation process. Since the program began in 1986, more than 1500 cases have entered CAAP. The majority of cases settle in CAAP and do not result in an arbitration hearing. The ratio of settlements to awards is about 3 to 1. Just over 50 percent of the awards are appealed, but so far virtually all of the appeals have resulted in settlements on appeal. Only one of the over 750 cases that have terminated after entering CAAP has ended in a trial.

In the evaluation effort, more than 600 CAAP and comparison cases have been surveyed, and more than 1000 surveys have been completed and returned by lawyers. Although the comparison group will figure heavily in the final evaluation, they are not included in this interim report because very few have closed so far. Furthermore, the comparison cases that have closed appear to be early closings (85% settled before an answer was filed by the defendant), and therefore they are probably not representative of the typical cases in regular litigation.

Data in this report are drawn from five sources: (1) a case record database maintained by the Arbitration Administrator; (2) surveys of lawyers and arbitrators, conducted after a case closes by settlement, award or dismissal, sampling cases in arbitration or in the comparison group; (3) surveys of lawyers conducted after an arbitration appeal is concluded; (4) interviews and focus group sessions with lawyers, arbitrators, insurance industry representatives and others involved in tort litigation; and (5) a general survey of the lawyers most active in CAAP.

The evaluation focuses on the following questions:

- 1) Is CAAP reducing litigant costs?
- 2) Do arbitrators and lawyers comply with the basic concept of limiting discovery?
- 3) Is CAAP increasing the pace of litigation?
- 4) Are cases closed within prescribed time limits?
- 5) Are participants satisfied with arbitration?
- 6) Is there an adequate supply of arbitrators?
- 7) Are arbitrators experienced enough and impartial?

PACE OF TERMINATIONS

The majority of lawyers report that CAAP is reducing the time it takes to terminate their case. The one exception is that a majority of defense lawyers report that their CAAP settlement would have taken about the same time to close in regular litigation.

Table 8: Estimates of Time Savings

	<u>PLAINTIFF</u>		<u>DEFENSE</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
TIME WOULD BE LONGER IF NOT IN CAAP	60 %	76 %	28 %	77 %

CAAP rules require that cases be completed within nine months (270 days) of the service of the complaint. Our analysis of the average time for closing cases, which we refer to as "pace," is based upon the first 567 cases that have closed in CAAP. The average pace is within the nine months for settlements and just over nine months for awards. We do not have a statistic from the judiciary on the average pace for cases in regular litigation, but numerous sources have indicated that cases in regular litigation go to settlement conferences 18-20 months after filing. Only 7 percent of settlements and 19 percent of awards in CAAP exceed one year. This data on pace excludes cases that terminated before the defendant answered, and such cases are approximately 1/3 of all cases closed in CAAP.

Table 9: Pace of Case Closings

	SETTLEMENT	AWARD
AVERAGE PACE LAST ANSWER UNTIL CLOSING	223 days	283 days
TIME FROM LAST ANSWER UNTIL CLOSING		
≤ 270 days	71%	52%
271- 365	22	29
> 365	7	19
AVERAGE PACE FROM ARBITRATOR ASSIGNMENT UNTIL CLOSING	167 days	197 days
TIME FROM ARBITRATOR ASSIGNMENT UNTIL CLOSING		
< 90 DAYS	10%	3%
91-180	51	35
181-270	32	52
271-365	6	8
> 365	1	3

While the overall program has a substantial number of cases that extend beyond the 9 month deadline, the arbitrators are able to terminate cases within nine months of assignment. In fact a significant proportion of cases are closed much earlier. 60% of the settlements and 38% of the awards occur within 6 months or less. It is the delay in assigning arbitrators to cases which accounts for almost 90 percent of the delays past nine months. The average time to assign an arbitrator from the case entering CAAP was 117 days, and from the defendant's answer was 67 days. The program administration reports that the delay occurs when all arbitrators are assigned to pending cases. Under the single case policy the program must wait for cases to close until 5 arbitrators are available to form a panel for each new case.

REDUCING DISCOVERY TO REDUCE LITIGATION EXPENSES

The reduction of pretrial discovery is a chief feature of CAAP, and it is the feature which is expected to produce lower litigant costs in Hawaii's program. Of more than 30 court-annexed arbitration programs across the country, Hawaii's appears to be the only program that is attempting to reduce discovery. Most other arbitration programs start to operate after discovery is completed. At most, they limit the time for discovery, but not the amount.

The majority of lawyers and arbitrators report that discovery was reduced in CAAP. Discovery can be reduced either because the arbitrator denies requests for discovery or because lawyers voluntarily agree to limit discovery. The discovery reduction appears to come mainly from lawyers voluntarily reducing discovery. Denials of discovery by the arbitrator take place in less than 1/3 of the cases.

Table 1: Estimates of Discovery Reduction

	<u>PLAINTIFF</u>		<u>DEFENSE</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
DISCOVERY REDUCED (say lawyers)	73 %	83 %	65 %	70 %
DISCOVERY REDUCED (say arbitrators)	80	92	84	93

Table 2: Views of How Discovery Was Reduced

	<u>PLAINTIFF</u>		<u>DEFENSE</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
VOLUNTARILY	86	83	67	71
REDUCED (say lawyers)				
	<u>PHASE I</u>		<u>PHASE II</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
VOLUNTARILY	--	--	85	83
REDUCED (say arbitrators)				

Table 3: Denial of Discovery

	<u>PHASE I</u>		<u>PHASE II</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
DENIED DISCOVERY	12 %	26 %	21 %	32 %
(say arbitrators)				

One concern about discovery reduction is whether it affects the outcome of the case. A significant percentage of lawyers think that discovery reduction did affect or may have affected the outcome of their case (this finding is less characteristic of settlements than of award cases).

Table 4: Effect of Discovery Denial

	<u>PLAINTIFF</u>		<u>DEFENSE</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
AFFECTED OUTCOME				
YES OR MAYBE	15 %	40 %	37 %	53 %
(say lawyers)				

Discovery reduction is important because a reduction in discovery will lower discovery costs, which are a part of litigant costs. The majority of lawyers report that discovery costs are lower in CAAP. The one exception is that majority of defense lawyers report that discovery costs for settlements are about the same in CAAP and regular litigation. Plaintiff's lawyers more often see CAAP as saving costs than do defense lawyers.

Table 5: Discovery Costs of CAAP

	<u>PLAINTIFF</u>		<u>DEFENSE</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
COSTS GREATER				
IF NOT IN ARB	67 %	56 %	28 %	52 %
(say lawyers)				

At this time we cannot say how much the program is actually reducing costs, and we cannot even confirm that it is reducing costs. Answers to these questions will not be available until more comparison cases close. However, we do have data on what the discovery costs have been for cases in CAAP. These discovery costs are reported in the table below. Keep in mind that the reported discovery costs for award cases underestimates the final discovery cost of these cases because more discovery is likely to be conducted if the case is appealed. The data show that discovery is more expensive in cases that go to awards than in cases that settle, and discovery for the defense is generally more expensive than for plaintiffs (the exception here is for Phase II awards). Interestingly, reported costs have declined somewhat from Phase I to Phase II even though Phase II includes higher valued cases.

Table 6: Discovery Costs Reported

AVERAGE DISCOVERY COST	<u>PLAINTIFF</u>		<u>DEFENSE</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
Phase II	\$322	\$980	\$479	\$865
Phase I	\$429	\$825	\$731	\$926

Discovery costs for the majority of defense surveyed were below \$400, and almost 2/3 of the plaintiffs had discovery costs of less than \$1,000. Only about 1/3 of the cases had discovery costs in excess of \$1,000.

Table 7: Ranges of Discovery Costs

DISCOVERY COST	<u>PLAINTIFF</u>		<u>DEFENSE</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
\$0-399	24%	37%	60%	50%
400-999	40	24	27	7
1000 +	36	39	13	43

Of course discovery costs are just part of total litigant costs. For the majority of cases we surveyed, for both the plaintiff and the defense discovery costs were 10 percent or less of the total costs. The largest part of litigant costs are lawyers' fees, not the discovery costs. We estimated the fees for plaintiffs' lawyers by computing 1/3 of the settlement or award value, which is the standard contingent fee percentage. In the cases for which we had the settlement or award amount, the lawyers' fees for plaintiffs' lawyers averaged \$10,946 for settlements (n=82) and \$9,186 for awards (n=51). The average fee

computed for awards includes defense awards for zero damages.² The plaintiffs' lawyer would not earn a fee in such cases.

For defense lawyers, the average fee was \$2,928 for settlements (n=45) and \$5,955 for awards (n=42). The fees for defense lawyers were taken from the figures reported by the defense lawyers on the surveys. Bear in mind that if the award is appealed, both plaintiffs' lawyers and defense lawyers will continue to work on the case. The fee for the plaintiffs' lawyers will not change even though these lawyers work more hours on the case because plaintiffs' lawyers are working on a contingent fee. In fact, the fee of the plaintiffs' lawyers is more likely to decrease because cases that settle on appeal often settle for somewhat less than the award.³ On the other hand, defense lawyers will continue to earn more fees when the case is appealed because these lawyers are working on an hourly fee. We cannot estimate the defense lawyers fees on appeal until more appealed cases close and can be surveyed.

For defendants, a reduction of discovery costs is likely to also reduce lawyers' fees because defense lawyers generally charge an hourly rate. If less discovery is allowed, presumably the defense lawyers will bill fewer hours on each case. If discovery is being reduced by CAAP, defense lawyers are probably making less money on each case they handle in CAAP. However, one effect of CAAP is that some insurance companies now pay defense lawyers a flat fee for handling cases through the arbitration hearing. We cannot estimate how prevalent the new flat fee system has become or even what the amount of the flat fee is. Neither insurance companies nor defense lawyers have discussed the specifics of the flat fee arrangements with us.

For plaintiffs, a reduction of discovery costs will not effect the lawyers' fee. Plaintiffs lawyers work on contingent fee, typically receiving 1/3 of the total settlement as the fee. After the plaintiff's lawyer's fee is deducted, the discovery costs and any other litigation expenses are subtracted and the plaintiff receives the remaining amount. Put simply, the fee of the plaintiffs' lawyer is not affected by the amount of work done by the lawyer; the fee is purely a function of the size of the settlement. If CAAP reduces not only the number of calendar days that a case remains open, but also reduces the amount of time a lawyer needs to spend preparing the case, plaintiff's lawyers could be making more money per hour with CAAP. Additionally,

2. Twenty-two percent of the awards were defense awards, and we did not calculate a contingent fee for these cases.

3. Of the first 29 cases that settled on appeal after an award, 18 cases, or 62 percent settled at a value of less than the award.

because plaintiffs' lawyers often advance the discovery costs, CAAP also will benefit plaintiffs' lawyers because they will now advance costs for a shorter period of time. Furthermore, earlier payment by the defendants to the plaintiffs will mean that plaintiffs will have the use of their money sooner, which is an economic benefit.

POTENTIAL SAVINGS IN LITIGATION COSTS

Although information from lawyer surveys indicates that the majority of lawyers think that CAAP is cheaper than regular litigation, until we have information from the comparison cases we cannot confirm that it is cheaper nor can we estimate how much cheaper it might be. However, we can provide a range of potential savings under certain conditions.

The first step is to estimate the number of cases that could be in CAAP. If a comparison group continues, approximately 1000 cases would enter the program each year; without a comparison group, approximately 1500 cases would enter the program each year.⁴ Please bear in mind that the following analysis is purely hypothetical; no data that has been collected that support these estimates of cost savings. However, it is easy to project the potential costs savings produced by CAAP at various levels of reduction of litigation costs. For every \$100 that CAAP could reduce litigation costs, total litigation expenses annually in the state could be reduced by \$100,000 if the comparison group remains in place.⁵ If the comparison group were eliminated, the potential savings would be approximately \$150,000 for each \$100 average savings.

4. In the fiscal years 1985-86 and 1986-87, each year there were approximately 1250 tort cases filed in the First Circuit. One-half of the cases are being placed in the comparison group and are not in CAAP. Approximately 500 tort cases are filed annually in all of the other circuits combined. Assuming that 10 percent of the cases in CAAP are exempted because they are estimated as being over the \$150,000 limit, state-wide, approximately 1012 would be eligible for CAAP each year (625 cases from the First Circuit plus 500 from the other circuits, minus 10 percent for exempted cases). If there was no comparison group, approximately 1575 cases would be eligible for the program each year (1750 cases from the First Circuit plus 500 from the other circuits, minus 10 percent for exempted cases).

5. This analysis assumes that 1012 cases average a \$100 reduction. The \$101,200 potential savings is rounded to \$100,000.

SATISFACTION WITH CAAP

We have not attempted to contact the individual litigants who have had cases in CAAP to ask about their satisfaction with the program. In most cases, individual litigants, especially injured plaintiffs, would not have had experience with other tort litigation, and therefore they could not compare CAAP to regular litigation. Instead we have asked the lawyers, virtually all of whom have had cases in both CAAP and in regular litigation, to indicate their level of satisfaction with the program and also to indicate what they think the level of satisfaction was for their clients.

The majority of lawyers reported being satisfied with CAAP when they were surveyed about a specific case. They are generally more satisfied with settlements than awards. Defense lawyers are less satisfied with both settlements and awards than are plaintiffs' lawyers.

Table 10: Lawyer Satisfaction

	<u>PLAINTIFF</u>		<u>DEFENSE</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
SATISFIED	96 %	75 %	75 %	63 %

ARBITRATORS, CASES & HEARINGS

Almost all lawyers report that the arbitrators were experienced enough to handle the cases and were impartial.

Table 11: Lawyers' Views of Arbitrators

	<u>PLAINTIFF</u>		<u>DEFENSE</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
EXPERIENCED ENOUGH	97 %	83 %	88 %	89 %
IMPARTIAL	98	89	97	90

Arbitrators averaged less than 5 hours of work on settlements and about 15 hours on awards. In Phase II the average hours of arbitrator work per case has decreased slightly from Phase I. The amount of time that arbitrators spend on a case varies widely. Half of the settlements are achieved in 3 hours or less, but 10 percent take from 9 to 30 hours. Similarly 20 percent of the awards take 8 hours or less, and 17 percent of the awards take from 21 to 50 hours. This data suggests either that cases vary considerably in the problems they present or that arbitrators vary considerably in their style and skill at managing the case, or perhaps both.

Table 12: Arbitrators' Work Hours

AVE. HOURS OF WORK BY ARBITRATOR	<u>PHASE I</u>		<u>PHASE II</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
	6.1	15.8	4.5	14.9
HOURS PER CASE				
0-3	39%	0%	52%	1%
4-8	41	26	38	20
9-15	12	40	6	41
16-20	4	12	2	20
21-30	2	8	2	14
31-50	2	14	0	3

The lawyers reported that the majority of the arbitration hearings took less than 4 hours to complete. However, 30 percent of the hearings took 5 to 8 hours and 7 percent took longer than 9 hours.

Table 13: HOURS OF ARBITRATION HEARING

HOURS OF ARB. HEARING		
1 - 4 HOURS	72 %	62 %
5 - 8 HOURS	20	31
9 + HOURS	8	7

The arbitrator is allowed to engage in the settlement process with the signed consent of all parties. However, less than half of the arbitrators report being formally involved in settlement efforts in Phase II, which is a proportion that has declined since Phase I. We have heard in interviews and focus groups that lawyers are not willing to allow settlement discussions with the arbitrator because if a mediated settlement fails, then the arbitrator would be improperly influenced by information acquired during settlement discussions.

Table 14: Settlement Activities

	<u>PHASE I</u>	<u>PHASE II</u>
	SETTLEMENTS	SETTLEMENTS
ENGAGED IN SETTLEMENT (say arbitrators)	71 %	41 %
ASSISTED IN SETTLEMENT (say arbitrators)	55	25

Data from CAAP records indicates that the average case is valued at about \$30,000. The average is higher in Phase II. Almost 90 percent of the cases have settlements or awards of \$50,000 or less.

Table 15: AVERAGE SETTLEMENT OR AWARD

	SETTLEMENT	AWARD
Phase II	\$28,191	\$31,426 ⁶
Phase I	\$20,880	\$21,244

Table 16: Amount of Settlement or Award

AMOUNT OF SETTLEMENT OR AWARD	Percentage Within Range
\$0 - \$ 50,000	89 %
\$50,001 - \$ 75,000	6
\$75,001 - \$ 100,000	3
\$100,001 +	2

When the jurisdictional limit was raised to \$150,000, many people speculated that higher valued cases would be more complex, and therefore inappropriate for an arbitration program. Very few cases in the \$150,000 program, however, are considered to be complex by the lawyers.

Table 17: Case Complexity

COMPLEXITY	<u>PLAINTIFF</u>		<u>DEFENSE</u>	
	SETTLEMENT	AWARD	SETTLEMENT	AWARD
	7 %	16 %	8 %	5 %

HEARINGS

Accelerated pace and cost containment in CAAP do not prevent litigants from having their "day in court." Plaintiffs were able to tell their stories to a neutral fact-finder by testifying in virtually all (96%) of the arbitration hearings. Defendants also had an opportunity to personally respond and their testimony was heard in 68% of those cases. Even though the plaintiff testified at almost every hearing, expert testimony was heard in only one third (36%) of the cases. Low levels of expert testimony at the hearings may represent an important cost saving for CAAP as well as resulting in less inconvenience for doctors and other professionals.

⁶. This average calculated from 130 cases includes the defense or zero awards.

IMPORTANT PROGRAM ISSUES

The issues of arbitrator quality, compensation, and supply, have received much attention from the Judicial Arbitration Commission. First, despite informal comments from the legal community that some of the arbitrators might not be qualified to handle cases or might be biased toward one side, the survey evidence is overwhelmingly the opposite. Lawyers reported that the arbitrator in their case was experienced enough and impartial. This disparity between the general lore and specific assessments may result from the CAAP procedure which allows each side to exclude the two most unacceptable arbitrators on the panel. While there may be some arbitrators that certain lawyers think are unqualified, the lawyers are usually able to exclude such arbitrators from their case with their preemptory challenges.

In discussions of CAAP, sometimes an arbitrator whose own law practice concentrates on representing plaintiffs in tort cases is called a "plaintiff's" arbitrator, and, of course, defense lawyers are called "defense" arbitrators. The implication is that "plaintiff" arbitrators will give a better, and presumably a higher, award to the plaintiffs and that "defense" arbitrators will be better for the defense. This assumption of arbitrator bias can be seen in the arbitrator selection process. When an arbitrator panel of five names is presented to the lawyers in each case, perhaps not surprisingly, plaintiffs' lawyers mainly strike defense lawyers and defense lawyers mainly strike plaintiff lawyers. The assumption is that plaintiffs' lawyers would favor plaintiffs and defense lawyers would favor defendants. However, the survey data indicates that 90 percent of the lawyers thought the arbitrator in their case was impartial.

An examination of the zero dollar or defense awards also suggests that bias does not exist. As of June 1988 the defense awards, are almost identical for "plaintiff arbitrators" and "defense arbitrators." In fact, on the basis of defense awards, a defense lawyer has a slightly better chance of getting a defense award from a plaintiff arbitrator. Plaintiff arbitrators made 13 defense awards out of 50 awards rendered; defense arbitrators made 11 defense awards out of 54 awards. Furthermore, the average dollar amount of awards also suggests either no bias or at most a slight reverse bias. As of June 1988, average awards were lower for plaintiff arbitrators (\$31,769) than for defense arbitrators (\$32,735). Our conclusion is that there is no indication that bias results from the type of the arbitrator's law practice.

Second, is the issue of arbitrator compensation. CAAP currently operates through the volunteer efforts of several hundred lawyers who serve as arbitrators. This "pro bono" aspect

of court-annexed arbitration is rare. Although no arbitration program in the country pays the arbitrators at a rate matching the income of a lawyer in private practice, most programs do at least offer an honorarium or stipend. Some people have suggested that CAAP should compensate arbitrators in some way to attract and retain arbitrators or because of the economic benefits of the program. In fact, the November general survey indicated that a third of lawyers responding thought paying arbitrators would improve the program, and this was the most common suggestion.

This evaluation does not take a position on this policy issue of arbitrator compensation, but offers several considerations. First, if CAAP actually reduces the costs and increases the pace of litigation, then clear economic benefits accrue to the defendant, the plaintiff, and the plaintiffs' lawyers, and there is an argument for compensating the lawyers whose time is used to produce these savings. None of the people or groups who appear to benefit economically from CAAP are typically considered to be indigent, and therefore none of them would be candidates for pro bono legal services.

Economic benefits may accrue to the person or corporation (typically an insurance company) who pays the defense costs, and who might save costs under CAAP; to the plaintiff who might receive both a larger share of the settlement if litigation costs are reduced and who might receive the settlement earlier; and to the plaintiffs' lawyer who might save the time value of money by advancing the costs of litigation for a shorter period of time. And with reduced discovery, defense lawyers and private court reporters who record depositions might be making less money on tort cases with CAAP. If these people are not making less money, then CAAP is probably not saving any costs.

Second, is an argument that some honorarium or other reward is necessary to attract, motivate, and retain arbitrators. Although lawyers might be willing to volunteer for a while, some lawyers might stop arbitrating unless they derive some personal or professional benefit.

If, under any theory, the argument for compensation is persuasive, a strong note of caution is advised. Until data from the comparison cases can be collected and analyzed, it cannot be determined how much money, if any, is being saved by using CAAP. Even if the CAAP savings is large enough to be significant, the savings could be offset by the payment of a stipend to the arbitrators.

Besides the economic argument against paying arbitrators, there are other arguments as well. CAAP might be a means of encouraging "pro bono" activity by lawyers whose practice expertise would not otherwise lend itself to traditional forms of "pro bono" activity. Furthermore, the amount of time that a

lawyer is likely to spend as an arbitrator each year is small. Many arbitrators might even be willing to contribute more time to the program voluntarily.

Finally, the long run capacity of the program is a significant concern. Under the present program policies and conditions, CAAP is strained to handle half of the First Circuit's tort cases within the 9 month deadline. The current supply of arbitrators is inadequate to handle all the tort cases eligible for arbitration if the comparison group were eliminated.

CONCLUSIONS

Hawaii's Court Annexed Arbitration Program appears to be meeting its goals of reducing litigant costs, increasing pace, and maintaining the satisfaction of participants. Although under the current operating procedures, it does not appear that CAAP could handle all the tort cases filed in Hawaii courts, the Judicial Arbitration Commission is working on this problem.

CAAP is delivering arbitration largely within the time frame prescribed by its rules, and is doing so to the satisfaction of the majority of lawyers. It clearly has succeeded in reducing pretrial discovery, and no other program can make that claim. After more comparison cases have closed, a later report will be able to provide data comparing pace, cost, and satisfaction in CAAP with regular litigation. To our knowledge, no other arbitration program in country claims to be reducing litigation costs; Hawaii leads the nation in this area.

GENERAL SURVEY RESULTS SUMMARY

In November, 1988, we sent a special "general survey" to the 91 lawyers (an almost equal number of plaintiff and defense lawyers) who handled the greatest number of arbitration cases among the cases we surveyed. These 91 lawyers were involved in 84 percent of the cases we surveyed. 62 lawyers completed and returned the survey (a 68 percent response rate). Although this general survey does not ask about specific cases, it does represent very recent general opinions from the lawyers who are the most active in CAAP.

PACE & COST

The lawyers indicated that most cases in CAAP were completed faster and cost less than cases in regular litigation. Ninety-two percent of all lawyers thought CAAP was faster than regular litigation and 83 percent thought it was cheaper. Eight percent thought cases took about the same amount of time, and 17 percent thought cases cost about the same amount. Not a single plaintiffs' or defense lawyer thought CAAP was slower or more expensive than regular litigation.

SATISFACTION

Seventy-eight percent of all lawyers reported that they were satisfied with the program, and 29 percent were dissatisfied. A major difference in satisfaction was found between plaintiffs' lawyers and defense lawyers. Ninety-one percent of the plaintiffs' lawyers were satisfied with the program, but only 46 percent of the defense lawyers were satisfied.

CHANGES IN VALUE OF THE CASES

Lawyers were asked what effect arbitration has had on the settlement value of tort cases eligible for the program. Thirty-three percent of lawyers believed that the settlement value has remained the same, 35 % thought the impact was unclear, 7 percent thought value decreased, and 25 % thought the value increased. Again, the major differences are between plaintiffs' and defense lawyers. Only 14 percent (3 of 22) of plaintiffs' lawyers but 42 percent (8 of 19) defense lawyers thought values have increased. Dissatisfaction by the defense lawyers is correlated to the opinion that the value of cases has increased.

ARBITRATOR SERVICE

Forty-seven percent (28 of 60) of all lawyers and 55 percent (21 of 38) lawyers who have served as arbitrators said that arbitrators should be willing to be assigned two or more arbitration cases at one time.

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***Report Of The
Governor's
Medical
Malpractice
Insurance
Commission***

October 1, 1975

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND
GOVERNOR

POUCH D — JUNEAU 99811

October 1, 1975

The Honorable Jay Hammond
Governor, State of Alaska
State Capital
Pouch A
Juneau, Alaska 99801

Dear Governor Hammond:

After long and careful deliberations the Commission of Alaska citizens which you appointed to study and make recommendations concerning the problem of adequate professional liability insurance availability for the medical profession is pleased now to submit its report including findings, recommendations and proposed specific legislation.

Our thorough investigation of this matter has convinced all the members of the Commission that the proposed solutions in our report are the most likely of any proposals reviewed by the Commission or enacted by legislatures of other states to encourage a significant improvement in the availability of adequate insurance.

The Commission believes that the draft of specific proposed legislation and a more comprehensive comment on the legislative segment of this report will require additional time to prepare and thus seeks the indulgence of the Governor in permitting the Commission to make a supplement to this report within an additional thirty days.

Yours sincerely,

Langhorne A. Motley
Chairman, Governor's Medical
Malpractice Insurance Commission

REPORT
OF THE
GOVERNOR'S MEDICAL MALPRACTICE
INSURANCE COMMISSION

TO

GOVERNOR JAY S. HAMMOND
STATE OF ALASKA

OCTOBER 1, 1975

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RECOMMENDATIONS

RECOMMENDATION NO. 1: (Page 18)

The liability of the health care provider should terminate three years after occurrence (two years statute of limitations and one year limit on discovery). Any reported cases after the third year ought to become the responsibility of a special fund and not the liability of the health care provider.

RECOMMENDATION NO. 2: (Page 20)

Any award to which the injured patient is entitled should be reduced by all available collateral sources such as private, group or governmental medical or disability benefits whether contributory or noncontributory, except life insurance, by precluding the introduction into evidence of the items of damage compensated by collateral sources, except federal programs which, by law, must seek subrogation.

RECOMMENDATION NO. 3: (Page 21)

Medical professionals should be immune from liability to a person who is not his patient for administering emergency medical care where the giving of immediate aid appears to be the only alternative to death or serious bodily injury or harm.

RECOMMENDATION NO. 4: (Page 22)

The law should provide that no promise to achieve a certain medical result is valid unless that promise is in writing signed by the health care provider.

RECOMMENDATION NO. 5: (Page 23)

The definition of medical negligence be improved by adopting a national standard of acceptable medical care in lieu of a local community standard, limiting the standard to that at the time of the act, and imposing the standard appropriate under all circumstances under which the health care provider was acting.

RECOMMENDATION NO. 6: (Page 25)

Cases brought more than three years after the date of the incident alleged to cause the loss complained of must be proven by evidence that is clear and convincing.

RECOMMENDATION NO. 7: (Page 27)

There be enacted provision for appointment of ad hoc medical expert panels composed of at least one physician and two health care providers of the same discipline as the health care provider charged, impanelled for filing of an action and prior to any pretrial proceedings, to initiate an investigation of available evidence and report to the parties its findings as to medical facts.

RECOMMENDATION NO. 8: (Page 27)

The findings of the expert medical panel be admissible as evidence and the panelists subject to cross examination in any subsequent trial.

RECOMMENDATION NO. 9: (Page 29)

There be established a medical adjudication board consisting of nine citizens of the State who are neither health care providers nor legal

professionals, nor insurers, and three physicians appointed by the Governor, and one Superior Court judge assigned by the court. This board would be the exclusive tribunal for medical negligence cases.

RECOMMENDATION NO. 10: (Page 30)

Upon the filing of a claim with the Medical Adjudication Board, the case be assigned to a Hearing Committee consisting of three of the citizens, one of the physicians and the judge who shall hear and finally determine the case.

RECOMMENDATION NO. 11: (Page 31)

The legislature enact a joint resolution for the amendment of Article I, Section 16, of the Alaska State Constitution, permitting the legislature to consider an alternative system of adjudicating medical negligence claims which may be a substitution for trial by jury.

RECOMMENDATION NO. 12: (Page 33)

Provisions be made to authorize and administer the awards of future income and continuing medical care to be paid periodically rather than in a lump sum.

RECOMMENDATION NO. 13: (Page 33)

Jury and board awards shall be rendered by category of loss.

RECOMMENDATION NO. 14: (Page 39)

Create a Health Care Providers Indemnity Corporation, a public corporation, which would be regulated by the Director of Insurance as a domestic

property and casualty insurer and which would be a mandatory and exclusive source of minimum limits of medical malpractice insurance for all health care providers for the losses reported within the first three years after occurrence.

RECOMMENDATION NO. 15: (Page 39)

The corporation may contract with servicing carriers for administrative and claims services and seek contracts of indemnity from admitted carriers retaining for itself no insurable risk.

RECOMMENDATION NO. 16: (Page 40)

The rates for the coverages provided by the corporation should be developed based on Alaska's experience and retrospectively adjusted over a four-year period such that each category of health care providers would fully pay for all losses and expenses incurred in the programs yielding an appropriate profit to the indemnity carrier.

RECOMMENDATION NO. 17: (Page 42)

The corporation provide coverage retroactively to January 1, 1975 with appropriate additional premiums for those health care providers which had no insurance during that period.

RECOMMENDATION NO. 18: (Page 42)

A joint underwriting association should be authorized to be implemented upon a finding by the Director of Insurance that indemnity at a reasonable rate is not available from a private carrier.

RECOMMENDATION NO. 19: (Page 43)

The joint underwriting association should be composed of all property, casualty and disability insurers and all health care service contractors.

RECOMMENDATION NO. 20 (Page 44)

Create a late claims fund which shall be funded by assessments against all health care providers in amounts determined by the Director of Insurance after public hearing as necessary to actuarially carry all fund liabilities and guaranteed by the State to the extent necessary to cover actuarial deficiencies. There should also be provision for the legislature to reduce the assessment of health care providers upon a finding that the assessment is unaffordable.

RECOMMENDATION NO. 21: (Page 45)

Legislation should be enacted which will require the maintenance of separate, specific and detailed statistical information on malpractice claims. Authority should be exercised by the Director of Insurance to more deliberately regulate policy forms and rates for this line.

RECOMMENDATION NO. 22: (Page 47)

The proposals of this Commission should inure to the benefit of, and be binding upon all licensed in the State as hospitals, as defined in AS 18.20.130 and including hospitals operated by State and political subdivisions, chiropractors, dental hygienists, physicians, osteopaths, chiropedists, nurses, opticians, pharmacists, and physical therapists, dentists, optometrists, psychologists and pediatricists.

RECOMMENDATION NO. 23: (Page 48)

There should be a legislatively prescribed procedure for informing the patient of the consequences of a procedure and obtaining the consent to perform it and also setting forth the conditions pursuant to which consent is implied or not required.

RECOMMENDATION NO. 24: (Page 49)

The appropriate licensing boards should be authorized to render disciplinary sanctions against health care providers other than license suspension. The boards should be able to reprimand, censure, place on probation, restrict practice by time, specialty, procedure or facility or to require continuing education or retraining.

RECOMMENDATION NO. 25: (Page 50)

The appropriate licensing board should have authority to require more relevant and more frequent reports on health care practices by and from its licensees. Persons reporting should have immunity from defamation actions based on reports made to licensing boards to officially constituted service committees of hospitals and professional health care organizations.

RECOMMENDATION NO. 26: (Page 50)

The legislature appropriate such additional funds as are needed to properly staff the health care licensing boards with investigative and administrative personnel.

RECOMMENDATION NO. 27: (Page 51)

Provision should be made for more effective loss control by all health care providers but with specific attention to identified problem areas.

I. THE CHALLENGE TO THE COMMISSION

BACKGROUND

For the past two years the physicians, surgeons and hospitals of the State of Alaska have been experiencing growing difficulties in procuring adequate insurance coverage for their malpractice exposures. The medical professionals, through their associations, societies and individually, tried to solve the problem by negotiating group marketing plans through Alaska insurance brokers with most of the traditional malpractice insurance carriers. Most doctors found insurance available at affordable rates provided they were rated in the lower risk categories and had continuing coverage with the same carrier for several years. New practitioners and those in higher risk categories or those who did not stay with a single carrier for a continuous period of at least two years, searched with more difficulty for coverage. Some found coverage through Lloyds of London, however, the Lloyds' coverage was on a claims-made form and, by July of 1975, Lloyds had determined to accept no new business or renew existing coverages. Brokers placed many physicians with a nonadmitted malpractice writer which issued a claims-made form and shortly after accepting placement of a substantial number of doctors, became financially unable to continue the business. Those physicians were placed with yet another carrier which, also for financial reasons, could not continue the coverage. For much of this period of time the Alaska State Medical Association was in discussions with an Anchorage Insurance Broker which was able, after much negotiation, to provide a market for malpractice insurance. The program offered, however, was on a claims-made form with no immediate assurance that protection against actions brought over three years after occurrence would be available. The program also lacked any reliable provision for excess coverage.

By January of 1975, it became apparent to the medical community in this State that legislative relief was required. Several factors contributed to this conclusion.

First, throughout the whole country, malpractice carrier insolvency, re-trenching insurance markets, extraordinary rate increases, growing malpractice judgements and rapidly increasing frequency of litigation was precipitating crises and legislative review at the federal level and in all states.

Second, the medical community in Alaska was becoming frustrated by the frequent shifting of markets, the lack of clear and reliable commitments of coverage and rates and misunderstanding about the degree of protection provided by the claims-made form of insurance.

Third, individual medical practitioners were expressing concern over the economic impact of the higher rates and restricted coverage on their own personal estates and making public announcements of discontinuing medical service unless relief was obtained.

Accordingly, the legislature, during the 1975 regular session considered and passed SB 361 which would, if enacted into law, provide for the immediate creation of a Joint Underwriting Association to which all casualty and disability insurers and health care contractors would be required to subscribe and which would be required to provide minimum limits of insurance to all doctors who wished it. On July 2, 1975, the Governor vetoed SB 361 for reasons outlined in the veto message.

Senate Bill 361 and the veto message are attached to this report as Exhibits 1 and 2.

In the veto message the Governor stated that because the problem of meeting the demands of the doctors without severely jeopardizing other important interests was so complex, he would appoint a commission "to develop a ——— thoroughly comprehensive package of legislation that [he planned] to introduce during the next session."

Appointment of Commission

In July, 1975, Governor Hammond appointed a representative group of Alaska citizens to serve on the Commission. The persons appointed were:

Langhorne A. Motley, Juneau, Chairman
Commissioner of Commerce & Economic Development
State of Alaska

Kenneth Atkinson, Esq., Anchorage
Atkinson, Conway, Young, Bell & Gagnon
Attorneys at Law

William bline, D.D.S., Anchorage
Dentist

Clyde Clary, Anchorage
President, Clary Insurance Agency, a division of
Bayley, Martin & Faye

Judy Hopkins, Anchorage
Legislative Representative
League of Women Voters

The Honorable Jalmar Kerttula, Anchorage
State Senator

William Kinn, M.D., Fairbanks
Ophthalmological Surgeon

Robert M. Libbey, Esq., Anchorage
Attorney at Law

Jamie Love, Anchorage
Alaska Public Interest Research Group

Robert Nestel, Anchorage
Risk Manager, Greater Anchorage Area Borough

Theodore M. Pease, Esq., Anchorage
Burr, Pease & Kurtz
Attorneys at Law

Donald Sharp, Anchorage
Vice President, Industrial Indemnity
Company of Alaska

The Honorable Theodore Smith, Anchorage
State Representative

Martin Tirador, Sitka
Administrator, Sitka Community Hospital

Jan Van Dort, Esq., Juneau
Faulkner, Banfield, Doogan & Holmes
Attorneys at Law
Legislative Counsel for American
Mutual Insurance Alliance

Barbara T. Walker, R.N., Duke Bay
Registered Nurse and Legislative Representative
Alaska Nurses Association

Robert Whaley, M.D., Anchorage
Internist, President Elect,
Alaska State Medical Association

Rodnan Wilson, M.D., Anchorage
Internist and immediate past President of the
Alaska State Medical Association

From time to time members of the Commission were unable to attend certain of the meetings and sent alternates. We are grateful for the participation of the following:

Thomas A. Stengl, M.D., Juneau
Physician

Richard Witt, M.D., Anchorage
Physician

Keith McGranahan, D.D.S., Anchorage
Dentist

Donald Chiles, D.D.S., Anchorage
Dentist

Josh Wright, D.D.S., Anchorage
Dentist and former legislator

Geraldine Morrow, D.D.S., Anchorage
Dentist

Thomas S. Redmond, D.D.S., Anchorage
Dentist

Ann Maiorello, R.N., Anchorage
Nurse

Arne Beltz, R.N., Anchorage
Nurse

Donna Brady, Anchorage
Alaska State Hospital Administration

Ernest Webb, Anchorage
Administrator, Anchorage Community Hospital

Thomas Bachelor, Esq., Juneau
Faulkner, Banfield, Doogan & Holmes
Attorneys at Law

Frank Doogan, Esq., Juneau
Faulkner, Banfield, Doogan & Holmes
Attorneys at Law

Charles Flynn, Esq., Anchorage
Burr, Pease & Kurtz
Attorneys at Law

John Hedland, Esq., Anchorage
Attorney at Law

Honorable Susan Sullivan, Anchorage
State Representative

The Commission was served by a staff consultant,

Richard L. Block, Los Angeles
Senior Vice President
Pacific Employees Insurance Company

and by staff assistants:

Donald P. Koch, Juneau
Division of Insurance
State of Alaska

Sandra Hoepfner, Anchorage
Division of Insurance
State of Alaska

Meetings

The Commission held twenty-four meetings in Anchorage and Juneau and three more meetings are scheduled. The schedule of meetings is attached as Exhibit 3.

All meetings were open to the public and the press.

The work of the Commission represents over 162 hours of meetings a period of 64 days.

Testimony

The Commission took oral testimony from fifty persons whose range of testimony exemplified their diversity of background. The list of witnesses and their special qualifications are listed in Exhibit 4.

In addition, substantial written material was reviewed by the Commission including legislation of other states, proposed legislation from several interested persons and groups, studies, reports, legal opinions, actuarial analyses, statistics and comments. Substantial portions of this material is listed as Exhibit 5.

Each Commission member, the Chairman and staff engaged in frequent deliberations and conferences with other Commission members, other interested persons and groups and shared with the Commission the results of such contacts. As a result of this supplemental activity by the Commission members, valuable information was obtained from the Providence Hospital, Blue Cross, Ad Hoc

groups of doctors including staff surgeons and anesthesiologists at Providence Hospital, insurance companies interested in providing coverage pursuant to the Commission's proposed plan and each of the interest groups which the Commission members represented.

Towards the last days of the Commission's deliberations the Commission conducted two briefing sessions. On September 3, 1975 the Commission presented the proposal to the legislators in conjunction with the meeting of the Western States Conference of Legislators in Anchorage. On September 5, 1975 the Commission presented the proposal to the medical profession at a meeting of doctors at Providence Hospital.

On Wednesday, September 25, 1975, the Commission presented the plan to the public in a widely viewed two hour television presentation over station KAKM, Anchorage. The taped presentation is scheduled for rebroadcast over station KUAC, Fairbanks and station KINY, Juneau.

Quest for an Immediate Solution

From the very beginning of the Commission's work, pressure from certain segments of the medical profession for an immediate solution mounted. Several surgeons and anesthesiologists had ceased performing routine surgery, the Providence Hospital was beginning to suffer from loss of revenue and public concern was growing.

After the first three days of meetings the urgency of the situation was recognized by the Commission and a tentative arrangement was suggested to

encourage the non-practicing doctors to return to work. An interim report to the Governor dated July 30, 1975 was submitted setting forth the sentiment of the Commission at that time. A copy of that report is attached in Exhibit 6.

The following week four more sessions were conducted, and although they were essentially fact finding sessions, collateral efforts by Commission staff led to an agreement with the broker for the Association malpractice insurance programs, which the Commission, including the doctor members, believed ought to temporarily relieve the pressure and permit the doctors to return to work while the Commission continued its study. That agreement is embodied in a letter from the broker attached as Exhibit 7 and was reported to the Governor on August 8, 1975 by a second interim report attached as Exhibit 8.

By August 14, 1975, the date of the Commission's next session, it became clear that the suggested interim solution was not acceptable to the non-practicing surgeons and anesthesiologists. Accordingly, the Commission discontinued any effort to solve the immediate problem and set about to design a solution which it could support as a permanent plan for improving the whole method of controlling, determining and indemnifying medical negligence.

Commission's Approach to the Problem

With the help of the staff consultant, the Commission developed topical outlines for its work which focused the Commission's efforts into an organ-

ized method of analyzing the problem.

It was early recognized that the medical malpractice insurance system involved three principal areas of concern.

First, malpractice, or professional negligence, requires the determination of questions such as defining a standard of due care by the professional, finding whether the services of the professional meet the standards of due care, whether, as a result of failure of the professionals to meet the standard, a person was injured and if so, to what extent, and finally the ultimate determination of whether, as a result of these findings, a money judgement ought to be made against the professional and in favor of the injured person, and, if so, in what amount.

These questions involve complex medical issues and require technical medical determinations, but the questions are resolved by the application of common and statutory law and are resolved according to established legal procedures for determining what allegations and evidence ought to be allowed as accepted fact.

These issues have traditionally been determined in common law civil courts applying the tort law principles of negligence or liability for fault.

If the evident difficulties with the availability of medical malpractice insurance are the result of the rules applied to determine whether an award should be made, or the current methods of determining the factual issues involved, then a change in the legal system would be necessary. A sub-

stantial amount of Commission time was devoted to analyzing the legal system, both as to the substantive rights of an injured person and the liability of an alleged tort-feasor, and as to the procedures and systems by which the facts are determined and the awards made.

The second area of concern was the method for distributing the costs of medical malpractice loss among the classes of persons available to pay the costs.

It became apparent to the Commission, after many hours of testimony, that, once, by error or omission of a medical professional, a person was injured, a loss of measurable amount was established. A decision was required as to who should bear the loss. The decision of how best to shift the burden of loss to the person or class of persons who ought to bear the loss must be deferred until the primary and, of course, more substantive policy question was decided.

To permit no remedies to an injured person does not eliminate the loss; it only implements the policy that the injured person should bear the loss. To permit no change in the tort law and fail to provide physicians with adequate insurance only implements the policy to shift the burden completely to the negligent physician. To create a wholly State funded insurance mechanism only implements the policy that the taxpayers should bear the burden of the loss.

As the Commission proceeded through the multitude of recommendations it received it found that every change in the tort law required the conscious

recognition that the burden of loss was being wholly or partially shifted to a new or different class of persons and the Commission struggled hardest on the equities of who should bear the loss.

Despite the difficulties of reaching a decision on the question, a decision on who should bear the loss was made and the Commission then dealt with the issues of finding the most economical and efficient means of so distributing the loss costs.

State mechanisms, private insurance mechanisms, and systems that utilized features of several different mechanisms were all explored.

Basic to its analysis, however, was the Commission's criteria that the system recommended must have reliability and stability, must be efficient of operation and must have the flexibility to accommodate the growth of the State and the individual concerns of the several different classes of medical professionals using the system.

Finally, the Commission refused to accept the premise that the total costs resulting from the errors or omissions of medical professionals was uncontrollable and reviewed carefully the several causes of loss cost to find and correct abuses.

There are three principal ways in which loss cost can be controlled.

First, the Commission studied the expenses inherent in the system for

determining the liability and damages; more specifically, the costs of the insurancing system, defense costs, legal fees, court system delays, long trials, multiple expert witnesses, and the added burdens to an injured person incurred by reason of an inefficient system.

Second, the Commission studied the amount of total cost because of the frequency and severity of incidents of medical negligence and studied ways in which the cost could be reduced by effective loss control practiced by the hospitals and medical professionals.

Third, the Commission studied the amount of total cost because of the ineptitude of practitioners who cannot be properly disciplined or whose practices cannot be appropriately restricted resulting from inadequacies in the State's licensing and regulatory authority and because of the ineffectiveness of what regulatory authority there is resulting from inadequate budget or staffing of the appropriate agencies.

Although the Commission studied the substance of the matter in its three principal aspects, the legal, the insurance and the medical, or its other three principal aspects, who should bear the cost, how should the costs be shifted and how can the costs be reduced, the Commission also considered the feasibility of its proposals from three aspects. The Commission sought the counsel of the Attorney General and the administration of the State's judicial system to be sure that whatever system was recommended would be constitutional and fit within the existing framework of the executive and judicial branches of State Government.

The Commission also remained in communication with insurance carriers to be

certain that any assumed immediate involvement of the private insurance industry was justified.

Finally, the Commission sought and received the continued guidance of its own legislative members and interested legislators not on the Commission to be sure that the recommendations of the Commission could realistically be expected to pass legislative review.

Criteria for Study

The Commission became clearly convinced that, if the objective of the whole system is to assure availability of appropriate coverage at reasonable rates, the system is not working.

Two principal reasons were determined to be dissuading carriers from providing the coverage, the actuarial uncertainty in the exposure to long tail losses and the rapidly increasing total cost of the system.

Any solution, then, must have, as an ultimate objective, creating appropriate adjustments to the mechanisms for determining distributing and reducing malpractice losses to restore actuarial predictability and to contain total system cost.

II. THE SOLUTION

AN ANALYSIS OF THE LEGAL SYSTEM

The Commission began its study with a review of the listing of malpractice actions in Alaska. Attached as Exhibit 9 is a report compiled by the Alaska State Medical Association and made public during the first days of the Commission deliberations in a feature story in the Anchorage News.

The Commission believes that the report is neither complete nor absolutely accurate, but the Commission does accept the report as being substantially correct, and sufficiently reflective of the magnitude of the problem as to be very useful.

It should be noted that Alaska has not had a high frequency of suits, few if any judgements, and no extraordinary awards. Taking only the past fifteen years' experience, it appears that no significant problem exists in Alaska, yet insurance carriers complained of escalating frequency of litigation and exorbitant awards throughout the rest of the country.

Upon further study two significant facts were determined.

1. Trends in law or judicial practice identified in the other states, particularly the major states, eventually become the law or the practice in Alaska. For example: The Alaska Supreme Court within the last two weeks adopted the rule of comparative

negligence in lieu of contributory negligence only a few months after the California Supreme Court did so by court decision.

2. There is a striking spread of malpractice litigation in the other states and frequent large judgements. The awareness of this phenomena is beginning to manifest a claims consciousness among patients in Alaska which is evident in a recent increased frequency of actually filed or threatened new law suits against Alaska doctors.

For two reasons, then, the Commission found it appropriate and necessary to make changes in the substantive law and procedures.

First, because Alaska would soon be faced with the same frequency and severity problems which are genuinely threatening the system in many of the other states; and, second, many carriers have designated certain tort law reforms as a necessary precondition to underwriting malpractice in a state.

LIMIT OF DISCOVERY PERIOD

One of the most repeated recommendations to the Commission, and the one which has commanded legislative appeal in many other states, is the cutting off of liability after a relatively short time after the date of incident. To understand this phase of the problem, one must remember that even though the law is clear that no action can be filed after a period of two years, the two year period is measured from the date the injured person knew or should have known that he was injured -- not from the date on which the injury was inflicted. In most kinds of injury, such as traffic accidents or property loss, the date of occurrence and discovery of the injury are for the most part simultaneous. In medical negligence cases, however, it is frequently the case that a patient may incur an injury but not become aware of it until many years later. Typical examples are negligent acts during obstetrical procedures not discovered until the child is old enough for the parents or doctor to detect brain or bodily impairment; injury in radiological therapy not discovered until the first symptoms of skin deterioration which may not become noticeable for many years; leaving a sponge, clamp, tool or towel in a surgery patient, which, because it causes no pain, is not discovered until a subsequent surgery, an Xray or later developed pain, none of which may necessarily be experienced for several years after the first surgery. The Commission heard examples of cases discovered as long as seven to twenty years after the date of incident.

When an insurance carrier sells a policy covering all negligent conduct of the physician occurring during the policy period, the carrier must respond

to and defend and indemnify whenever those cases are legally brought. Thus, carriers are exposed to liability for unknown losses for upwards of twenty years when they issue a policy to a health care provider. This actually incurred liability with respect to policies issued many years ago and the recognized need to post adequate reserves for the future contingencies on current policies has been the principal reason for the large rate increases in malpractice insurance and the reason some relief has been sought in a new policy form which covers only claims made during the policy period instead of claims incurred during the policy period.

The suggestion of strictly limiting the period of discovery is made to reduce the otherwise unlimited exposure or tail exposure to the carriers or insureds.

The Commission found that a limit on the discovery period is a very necessary part of any meaningful program and has included this as an integral part of its proposal; but for two reasons, the Commission rejected making the limit an absolute preclusion of patients' rights.

First, the Commission did not believe it equitable to shift to the injured patient any segment of loss because, for some reason beyond the patient's control, he could not discover the fact of loss until after the arbitrary date, and second, the Commission was concerned about real constitutional questions raised by such an absolute cut-off of rights.

To harmonize the desire to reduce the contingent exposure of the physicians without arbitrarily terminating legitimate rights, the Commission made the following recommendation:

Recommendation: [No. 1]

The liability of the health care provider should terminate three years after occurrence (two years statute of limitations and one year limit on discovery). Any reported cases after the third year ought to become the responsibility of a special fund and not the liability of the health care provider.

Reducing Ultimate Awards

The Commission studied several proposals which, would cut the total cost of the system by reducing the size of the awards.

The advocates of mandatorily limited awards cited two identifiable impacts. First, it is believed limited awards would have the obvious impact of reducing the now unlimited exposures on legitimately filed actions. The Commission reviewed limits on total awards, limits on general damages, scheduled benefits and several variations of each of these concepts. It is true that any such proposal has the potential for reducing exposure, but the amount of the reduction is speculative at best. By the same token, there was concern expressed that any schedule of benefits or arbitrary limits on awards would become, in practice, minimums rather than maximums and defeat the purpose of the proposal.

More importantly, however, it was recognized that there existed examples where a seriously injured person would suffer extreme loss that would only

be adequately compensated by an award that might exceed any limit prescribed.

The second predicted impact is that by eliminating the portion of the awards which is in excess of the patient's actual out-of-pocket losses, the incentive of patients and the incentive of lawyers to bring suit would be eliminated. The limitation of the award might have some impact on a lawyer's willingness to take a malpractice case, however, the Commission was unwilling to place arbitrary roadblocks that would preclude the legitimate claimant from having recourse to counsel and the courts for redress.

The Commission, thus, rejected arbitrary limits on awards.

On the other hand, it was discovered that frequently a person would be allowed an award predicated upon out-of-pocket losses which, in fact, were wholly or partially compensated from other or collateral sources. The result is potential for double recovery, and the presentation of the additional complications of subrogation and collateral source liens.

In determining how to approach eliminating the double recovery or subrogation problem, it was determined that overall cost would be reduced if the patient was required to first utilize the first party coverages to which he is entitled, which are much more efficient forms of distribution than allowing the full measure of damages in an expensive third party proceeding, and then deny the patient the right of alleging, in the malpractice action, the items of damage which were compensated by the collateral sources.

Recommendation: [No. 2]:

Any award to which the injured patient is entitled should be reduced by all available collateral sources such as private, group or governmental medical or disability benefits whether contributory or noncontributory, except life insurance, by precluding the introduction into evidence of the items of damage compensated by collateral sources, except federal programs which by law must seek subrogation.

Control of Legal Fees

The Commission addressed the issue of attorneys' fees, which, unfortunately, has become one of the more emotional issues in the malpractice situation.

Contingency fees, or fees based upon the size of the award, have become highlighted because of the size of the few cases in which lawyers have been successful in obtaining substantial awards. The Commission found, however, that the overall remuneration of attorneys that engage in this type of practice is not unduly high when the cases which require substantial effort and result in defense verdicts or in modest plaintiff's verdicts are considered.

Further, contingency fee arrangements may often be the only way that injured persons can obtain separation because of their inability to compensate the lawyer on a regular time fee basis.

Nonetheless, the Commission recognizes that a significant element in the cost of the system is the fee for both plaintiff and defense lawyers.

The court rules of Alaska, Rule 82, already make provision for court involvement in the matter of legal fees. The Commission believes that the court should go further and exercise its authority to more carefully review attorneys' fees actually paid to both plaintiff and defense lawyers. The same principle should apply in proceedings before the adjudication board discussed below.

Precluding Certain Liability

Several examples which came to the attention of the Commission where the concern for exposure to possible litigation overrode the doctors' concern for the life and health of either patients of that doctor or persons requiring immediate medical service with whom the doctors came in contact.

For example, emergency cardiac arrest of a patient in a hospital requires immediate remedial action to resuscitate the heart. Normally, the closest medical professional rushes to the bedside and administers aid. Because of the potential malpractice exposure to the administering medical professional if, in the haste to save a life, the professional errs in the rendering of such care or is too late to permit resuscitation to be totally rehabilitative, doctors are "walking slow" in response to such emergencies. To encourage the rendering of critical emergency care the Commission recommends:

Recommendation: [No. 3]

Medical professionals should be immune from liability to a person who is not his patient for administering emergency medical care where

the giving of immediate aid appears to be the only alternative to death or serious bodily injury or harm.

Doctors cited several examples of actions brought by patients who were treated properly but who did not achieve the state of medical health which the patient regarded as promised by the treating physician. These actions were brought, not for medical negligence, but for breach of warranty or for breach of a contract to achieve a specific result.

There are circumstances where the doctors do make a promise of a specific result and where it would be appropriate to permit liability where the promised results are not obtained. On the other hand, the doctor is entitled to at least the protection of requiring a quantum of proof that precludes any claim of a promise to achieve a specific cure in circumstances where no promise was actually intended. Accordingly the Commission recommends:

Recommendation: [No. 4]

The law should provide that no promise to achieve a certain medical result is valid unless that promise is in writing signed by the health care provider.

Defining the Standard of Care

One of the thorniest issues posed to juries is the definition of the standard of care by which health care providers' conduct is adjudged.

In 1967, the Alaska legislature adopted a statutory definition of the standard of care that an injured patient was required to prove in a malpractice case. That statute, AS 09.55.530 et. seq., is a more clearly defined standard than exists today in many states. Nonetheless, it requires further refinement to make the standard more relevant to the higher standard of medical service available in the State today and to establish more appropriate conditions upon actions for medical negligence. The Commission believes that the standards to which Alaska health care providers must adhere should be the national standard of acceptable medical care; it is no longer necessary or appropriate to measure the performance by a local community standard. The Commission recognized, however, that at trial, the standard should be measured taking into account the time and circumstances under which the act or omission complained of was incurred. The Commission, therefore, recommends:

Recommendation: [No. 5]

The definition of medical negligence be improved by adopting a national standard of acceptable medical care in lieu of a local community standard, limiting the standard to that at the time of the act, and imposing the standard appropriate under all circumstances under which the health care provider was acting.

Burden of Proof

The Commission received numerous suggestions for modifying the burden of proof from the current requirement that the plaintiff or injured patient

must prove his case by a preponderance of the evidence to a standard more demanding of the plaintiff. The reason for such suggestion was assuring that the case against a health care provider was sufficiently proved by available creditable evidence that spurious or genuinely doubtful cases are precluded.

Over the years, the current test applied in all negligence cases has served well and the Commission does not believe it warranted to carve out a special exception in medical cases which would make it more difficult for the legitimate cases to be adjudicated.

On the other hand, as previously noted, the Commission believes special treatment ought to be accorded claims which are brought over three years after the date of occurrence. Several reasons suggest the justification for applying a more rigid rule to those cases. First, where the case is not discovered for over one year after date of incident, the degree of harm or pain to the patient is often of lesser severity than in cases where the negligence is obvious from the outset.

Second, the more delayed the trial is from the date of incident, the more likely it is that the evidence relevant to the case is destroyed, stale, or not subject to verification. For example, X-rays and many hospital records are destroyed after several years. More importantly, however, a deferred trial date means that the testimony from witnesses, experts and the defendant doctor becomes more clouded by conjectures and lack of clear recollections. This has the potential effect of submitting to the jury a case based on inexact or incomplete testimony and evidence, allowing the

most lay jurors have difficulty understanding.

In a typical medical negligence case, the determination of appropriate medical procedures are matters which jurors must decide after hearing testimony from expert medical technicians which are paid to testify by the parties to litigation calling them as witnesses. The testimony, therefore, is generally conflicting and often equally persuasive.

Most medical negligence cases require substantial and expensive pretrial preparation including extensive discovery and investigation. Often the parties proceed believing their own medical experts, whereas an independent impartial expert opinion might encourage settlement or resolution prior to the lengthy, expensive and often traumatic pretrial proceedings.

Two reasons, then, suggest the advisability of interjecting an expert medical advisory panel into the trial proceedings to aid the jury in resolving conflicting medical testimony and to provide the parties with an early expert opinion.

The function of an expert panel would be to analyze all available technical documentary evidence and to interview and examine the plaintiff, interview the defendant doctor and other experts and to initiate their own review of the circumstances in an informal, yet thorough, manner and issue a report to the parties concerning their conclusions as to medical facts.

To carry out this function effectively, the Commission perceives the panel as composed of at least one physician and two other health care providers of the same discipline as the health care provider charged. The panel would be

appointed jointly by the court and the parties pursuant to carefully delineated procedures, immediately after filing of the case and prior to any discovery or other proceedings in the litigation. Special procedures would be adopted for cases involving multiple defendants.

-----The findings of the expert panel, which would include a determination of the appropriate standard of care, whether the health care provider violated that standard, and the measure of injury resulting from the medical negligence, would be given to each of the parties before they could proceed with pre-trial matters. If the case proceeded to trial, the findings of the panel would be admissible into evidence and the panelists available for cross-examination.

Recommendation: [No. 7]

There be enacted provision for appointment of ad hoc medical expert panels composed of at least one physician and two health care providers of the same discipline as the health care provider charged, impanelled after filing of an action and prior to any pretrial proceedings, to initiate an investigation of available evidence and report to the parties its findings as to medical facts.

Recommendation: [No. 8]

The findings of the expert medical panel be admissible as evidence and the panelists subject to cross-examination in any subsequent trial.

Use of Medical Adjudication Board

Probably one of the most significant contributors to the high cost of the medical negligence reparation system is the expense of the proceedings necessarily incurred when a jury trial is involved.

To properly prepare a case for jury trial more elaborate presentations of medical testimony must be readied. Trials are long because of the procedural care taken in the admission of appropriate evidence. Substantial administrative expense is incurred in the use of State personnel and in jury costs. Comment has already been made of the difficulty of requiring a jury to deal with medical technology with little or no prior preparation.

These considerations led the Commission to explore a variety of other methods of determining the facts of a case. Included were arbitration, screening panels, State administrative hearing procedures, and other similar alternatives.

The Commission rejected any mechanism that required a total review of the evidence and the making of findings and awards, if there was preserved the right of a subsequent trial de novo before another tribunal.

Screening panels and nonbinding arbitration for example generally permitted the parties to proceed to a rehearing before a jury resulting in a duplication of expense rather than a saving of expense.

The Commission also rejected any system that requires the establishment of a whole new governmental agency. The frequency of cases expected to be brought for medical negligence are expected to remain so relatively few that a new agency seems unjustified.

-Voluntary binding arbitration was analyzed and found to be a procedure of considerable merit. In many states provisions have been made in the law which allow the health care provider to require an arbitration agreement before treatment.

The law in Alaska today is such that agreements to submit controversies to binding arbitration are legal if the agreements are not obtained under duress. The Commission believes that the law in this regard should not be changed, and that the medical professions should explore wider use of arbitration agreements.

The Commission has, therefore, recommended:

Recommendation: [No. 9]

There be established a medical adjudication board consisting of nine citizens of the State who are neither health care providers nor legal professionals, nor insurers, and three physicians appointed by the Governor, and one Superior Court judge assigned by the court. This board would be the exclusive tribunal for medical negligence cases.

Recommendation: [No. 10]

Upon the filing of a claim with the Medical Adjudication Board ,
the case be assigned to a Hearing Committee consisting of
three of the citizens, one of the physicians and the judge who
shall hear and finally determine the case.

A committee of five is believed adequate for a proper hearing of the type envisioned, yet a larger board from which the specific committee is chosen is necessary in order to permit rotation, assure availability and preclude persons sitting on cases in which they may have a conflict of interest.

It is appropriate to have a fixed board of thirteen, however, in order to permit the persons responsible for hearing medical negligence cases to acquire skill and also because the board would be expected to have sufficient continuity to enable it to enact rules of procedure and to oversee the administration of these cases within the judicial system.

In order to assure due process, judgements of the committee of the board would be appealable to the Supreme Court in the same manner as appeal from a jury verdict.

It is envisioned that the procedures before the board would be greatly simplified and that the use of the expert medical panel would continue before the board proceedings as it is now recommended it function before a jury trial.

It is further believed that such a board procedure will accomplish the desirable result of making the system more accessible so that persons could seek and obtain a just result without the necessity of a lawyer and so that small cases could be handled with sufficient economy that persons with small but legitimate claims could be compensated.

Constitutionality

The State Attorney General expressed the opinion to the Commission that the concept of the Medical Adjudication Panel would violate the Alaska State Constitution unless access to the jury was ultimately available to the parties.

The Commission firmly regards it inappropriate to establish an administrative procedure for determining those matters and then dilute the effect of the tribunal's findings and compound the expenses by allowing a retrial of the matter before a jury. Therefore, the Commission recommends:

Recommendation: [No. 11]

The legislature enact a joint resolution for the amendment of Article I, Section 16 of the Alaska State Constitution, permitting the legislature to consider an alternative system of adjudicating medical negligence claims which may be a substitution for trial by jury.

The Commission recognizes that the constitutional amendment and, thus the

medical adjudication panel, cannot be enacted before the general election in 1976. All other phases of the Commission's proposal, however, including the provisions for a medical expert panel, can be enacted and implemented immediately and would require no subsequent changes when the Medical Adjudication Board becomes a reality.

Periodic Payments

The Commission evaluated the equity of awarding lump sum benefits to an injured patient and found that there were inequities in granting lump sum awards and considered available alternatives.

Several examples were received in which a substantial award was conferred upon a person severely injured based primarily upon a life expectancy of many more years than the plaintiff could reasonably be expected to actually live in view of the medical situation.

The large award for reasonably anticipated lifetime medical care and reimbursement for loss of future earnings is reasonable and not questioned by the Commission even though the awards necessary to compensate for these damages were frequently unusually large. What does become an inequitable charge to the system is the windfall to heirs or others if the patient-plaintiff dies shortly after the award is made. It is also inequitable for a person who outlives the projected life span to be left destitute because the funds ran out.

Periodic payments and annuities are not prohibited now in Alaska where the

cases are settled prior to trial. The Commission believes, however, that the substantial value of permitting periodic payment plans requires that it be encouraged for the distribution of jury or board awards.

Recommendation: [No. 12]

Provisions be made to authorize and administer the awards of future income and continuing medical care to be paid periodically rather than in a lump sum.

Itemized Awards

The juries are currently awarding damages in a single indivisible verdict, even though the damages alleged are for different categories of loss. Much of the proposal of the Commission contemplates the court, the medical adjudication board, the insuring entities and those concerned with control of loss, knowing for what categories of loss, that is, medical expense, lost earnings, future loss of income, general damages or other categories of loss the awards are intended.

Recommendation: [No. 13]

Jury and board awards shall be rendered by category of loss.

THE INSURANCE SYSTEM

The thrust of the whole problem for the hospitals and physicians is the unavailability of professional liability insurance coverage at a reasonable price.

Several factors were found to have contributed to much restricted markets.

Within the last two years, the insurance industry has suffered an underwriting loss of heretofore unmatched proportions.

In addition, many insurance companies found themselves heavily invested in securities dramatically affected by the severe drop in market values which, while not affecting income or loss, except for those carriers forced to sell at a loss to raise cash, had the affect of materially reducing net worth to the point that the industry was, and still is, required to reduce their premium writings in order to keep the ratio of writings to surplus within acceptable parameters.

Thus, carriers were, and still are, forced to evaluate which of its lines or books of business must be reduced or eliminated to reduce writings and increase the potential for profit.

Obviously, the catastrophic developments in medical malpractice insurance losses resulting from the factors of claim consciousness and the tail exposure explained above made this line of insurance an obvious candidate for elimination from carrier portfolios.

The problem was compounded when, in the latter part of 1974, Argonaut Insurance Company first announced that because of its seriously impaired financial condition, it was withdrawing entirely from the physicians malpractice field and precipitated a publicly aired outcry from the medical profession and insurance regulators.

Although these matters related little to the results on the malpractice business sold in Alaska, the decisions to substantially increase rates or withdraw from the field affected Alaska only because the carriers allowed for no special consideration for possible profitable business in very small market areas.

One of the historically most reliable sources for malpractice insurance has been Lloyds of London which has, for many years, marketed a claims-made form. More recently, American carriers responded to the malpractice insurance problem by switching from an occurrence form to a claims-made form. Unfortunately, little attention was paid by doctors to the policy form until it became a visible issue and the doctors became alarmed at the possibility that, at retirement or discontinuance of practice or discontinuance of the insurance program, they would have a residual exposure not covered by insurance.

The degree to which these fears are justified depends upon the structure of the program provided. For example, under the Lloyds form, three years of discovery time after the last year of coverage was provided at no additional cost. For a while it was possible to procure tail protection for the period beyond three years for additional premiums.

Marsh & McLennan offers a program through Shand, Morahan & Company, Inc., which provides three years of discovery protection after the last year of primary protection for additional premium, but no protection for discoveries after three years..

In some other states, St. Paul Fire & Marine offers a claims-made program which is guaranteed renewable but without a guarantee of a certain rate and guarantees the availability of occurrence form tail protection after the last year of claims-made coverage for an agreed percentage of the then year's rates for the basic coverage.

The confusion over the cost and kind of protection provided led most Alaska physicians to refuse all claims-made coverage until satisfactory protection of late discovered claims and proper pricing was obtained.

Probably the greatest confusion came about in the eyes of the Alaska public when several high risk class doctors proclaimed publicly that they were paying \$36,000 per year for coverage. As a matter of fact, under the Marsh

& McLennan program which was cited as an example, that price was found to include provision for three years of discovery protection which, so long as the practitioner practices and continues to purchase basic primary coverage every year, would not be needed until after the last year of practice, retirement or discontinuance of the insurance program. The one year premium for the basic primary coverage including limits to \$1,000,000 was found to be \$18,000 per year. The detail of this premium is shown on Exhibit 10.

Overall the premiums for malpractice insurance for hospitals and physicians

has not been demonstrated to relate exclusively or even primarily to Alaska's experience. Testimony before the Commission indicated that development of Alaska's malpractice experience indicates a lowering of rates.

Unfortunately, the one admitted carrier writing in Alaska and thus required to file rates, provides occurrence coverage at modest rates but has not written medium or high risk specialties and is taking no new risk.

The other providers of coverage are nonadmitted carriers and thus not bound to any filed rate. The rate schedules used are based more on national statistics which results in exceptionally high rates.

The examination of rates led to two important observations about the Alaskan insurance market.

First, there is now no place, either in a governmental agency or any private carriers where statistics which are specific, reliable and credible are accumulated.

Second, the health care providers in this State are few in number and, thus, even if taken all together are a difficult class over which to distribute risk. Despite that fact, the doctors have continued to procure insurance from many different sources with the result that no carrier had a sufficient book of business to make it economically or actuarially worthwhile to continue their participation in the State.

For example, from available statistics it was generally found that doctors were, in early and mid 1975 procuring their insurance from:

<u>Carrier</u>	<u>Number of Doctors</u>
Continental Insurance	100
Lloyds of London	50
Marsh & McLennan	15
National OB-GYN Group	20
National Internists Group	20
Group Practice Program	50
Voluntarily uninsured	<u>60</u>
Total licensed physicians	315

It was found that currently most nurses and other health care providers are not having problems procuring coverage at a reasonable price. Hospitals, are having difficulty obtaining adequate coverage and quotes on renewals indicate that costs are about to increase dramatically.

The most serious concerns identified by the hospitals and physicians were:

- a) incomplete coverage for the late reported cases;
- b) lack of continuity in the insurance program;
- c) rates not related to Alaska's experience;
- d) no assurance that coverage would be available at any price on a permanent basis.

Health Care Providers' Indemnity Corporation

To bring some constancy to the insurance program, the Commission felt that the only way a group as small as the physicians' group in Alaska could successfully negotiate for coverage would be to act in concert, bringing to bear the bargaining power of all of the malpractice premiums in the State.

Historically, the medical association in this State has been unable to galvanize their membership into a common malpractice program. It, therefore, seems necessary to legislate the programs.

Recommendation: [No. 14]

Create a Health Care Providers Indemnity Corporation, a public corporation, which would be regulated by the Director of Insurance as a domestic property and casualty insurer and which would be a mandatory and exclusive source of minimum limits of medical malpractice insurance for all health care providers for the losses reported within the first three years after occurrence.

The Commission does not feel that at this time it is necessary or proper for the State to be financially involved in the program. Rather, the amount of premium which would flow through the system, if all health care providers are included, and if the rating structure is predictably profitable, should be attractive to many private insurers.

Recommendation: [No. 15]

The corporation may contract with servicing carriers for

administrative and claims services and seek contracts of indemnity from admitted carriers retaining for itself no insurable risk.

Rates

In order for the program to be economically successful and also to carry out the principle that the health care providers should bear their own true costs,

Recommendation: [No. 16]

The rates for the coverages provided by the corporation should be developed based on Alaska's experience and retrospectively adjusted over a four year period such that each category of health care providers would fully pay for all losses and expenses incurred in the programs yielding an appropriate profit to the indemnity carrier.

The physicians testified that the six classification rating system utilized almost universally by carriers in pricing malpractice coverage has greatly exaggerated the difference in exposure for high risk and low risk doctors. They noted that a different rating structure would be more equitable and affordable if it reduced the cost to the high risk physicians even if it required increasing the rates to low risk physicians.

There has been a preference expressed for rating physicians on gross

medical revenues, since, at least theoretically, the gross medical revenues of a physician reflect the degree of complexity and risk in the physician's practice.

Each of the health care providers other than physicians and hospitals have expressed concern that by being included in a mandatory insurance program they will be required to pay higher premiums to fund the bad experience of the more hazardous categories of health care.

The use of the indemnity corporation allows sufficient flexibility in the rating plans which it uses, that any cost distribution which the health care providers prefer and which generates sufficient total revenues, can be implemented.

It has been determined by the Commission, however, that no health care providers category should subsidize any other category; each should be self-rated within their separate fields.

Retroactive Coverage

Throughout the year, 1975, the doctors have been subjected to uncertainty about the coverage and its costs and have incurred intermittent periods when they have been practicing without proper insurance.

When the crisis was at its worst, several surgeons, some anesthesiologists and others continued their practices, either without coverage or without adequate provision for tail protection.

The Commission believes that it is appropriate that provision be made to provide protection to these doctors.

Recommendation: [No. 17]

The corporation provide coverage retroactively to January 1, 1975 with appropriate additional premiums for those health care providers which had no insurance during that period.

Joint Underwriting Association

It is conceivable that no private market will seek to indemnify the corporation. To provide consistency of the program there must be some standby mandatory availability:

Recommendation: [No. 18]

A joint underwriting association should be authorized to be implemented upon a finding by the Director of Insurance that indemnity at a reasonable rate is not available from a private carrier.

A joint underwriting association is a means of spreading potential loss through insurers to classes of insureds other than the class of insureds subject of the primary risk. It serves a useful purpose when, for reasons beyond the control of the carriers, the coverage can be obtained no other way.

The joint underwriting association recommended by the Commission differs from that which was the subject of SB 361 passed by the legislature earlier this year in three particulars:

- a) This joint underwriting association is recommended only as part of a total scheme designed to address both the symptoms and fundamental causes of the problem. This is important. Enactment of a joint underwriting association without making the other fundamental changes only transfers the basic problem; it does not solve it.
- b) By reason of the other changes in law recommended by the Commission, the joint underwriters association would only be indemnifying losses reported within the first three years after occurrence. The joint underwriting association in SB 361 had continuing liability for the tail exposure.
- c) The joint underwriting association in SB 361 was not an exclusive source for malpractice insurance. The joint underwriting association proposed by the Commission would indemnify the mandatory and exclusive corporation insurance program. This difference is significant. Because of the rating structures proposed by the Commission, a relatively good spread of risk can be achieved without unreasonable cost to any health care provider and no on-going loss to the plan.

Where the joint underwriting association is permissive only, the good

risks will be written by the private carriers providing reasonable rates through national underwriting programs and the high rated classifications and poor risks will be forced into the joint underwriting association bringing the rates up for the residual doctors or causing an ongoing loss to the plan or, most likely, both.

The insurers which ought to participate in the joint underwriting association are those which are most benefited by the quality and cost of health care and which can best distribute any costs borne for this program over the widest possible base.

Recommendation: [No. 19]

The joint underwriting association should be composed of all property, casualty and disability insurers and all health care service contractors.

The Commission has given serious consideration to including the unlicensed medical and disability programs of labor unions. It is the opinion of the Commission that these programs are equally capable of sharing in this cost and ought to do so. Because, however, they are unlicensed and, thus, to include them would require the consideration of issues not now before the Commission, it is suggested that the legislature explore the feasibility of their inclusion.

Late Claims Fund

Because of the cutting off of health care provider liability three years after occurrence, the source for recovery on late filed claims must come from a separate fund.

The Commission considered the question of how to fund the fund at great length

There is a potential for exposure to late claims that could result in substantial system expense. This was, after all, the reason most insurance carriers elected not to continue responsible for such exposure. The Commission points out that there is a need for a State guarantee of the fund to cover a claim made which exceeds the fund assets. There may be the further need for State participation if the cost to the health care providers to properly fund the fund becomes unaffordable.

The Commission believes that provision should be made for administrative determination of the actuarial requirements of the fund for each category of health care provider and that the legislature determine the degree to which a governmental guarantee ought to be allowed.

Recommendation: [Ho. 20]

Create a late claims fund which shall be funded by assessments against all health care providers in amounts determined by the

Director of Insurance after public hearing as necessary to actuarially carry all fund liabilities and guaranteed by the State to the extent necessary to cover actuarial deficiencies. There should also be provision for the legislature to reduce the assessment of health care providers upon a finding that the assessment is unaffordable.

Statistics

The existence of a single source for malpractice insurance will necessarily result in many improvements in the statistical, reporting and reserving requirements for this line. Nonetheless,

Recommendation: [No. 21]

Legislation should be enacted which will require the maintenance of separate, specific and detailed statistical information on malpractice claims. Authority should be exercised by the Director of Insurance to more deliberately regulate policy forms and rates for this line.

This information will enable future administration and legislatures and, of course, the health care providers and insurers, to make more informed judgements about the coverage and its costs.

Health Care Providers

Defining health care providers to be included in the proposal is based upon the following considerations:

- a) Since the program is mandatory, some efficient means of enforcement is necessary. Using the licensing agency as a means of assuring compliance with the mandatory insurance provisions was regarded as most appropriate since it coincides with the proposal calling for the licensing boards to more effectively regulate the health care providers.
- b) One of the values of a common source for indemnification of all health care providers is the ability to provide a common defense. There is a significant cost savings if all those who might be involved in a malpractice action would be in the program.
- c) One of the purposes of requiring all insurance for health care providers to be purchased from one source is to make the size of the program large enough to be attractive to the private insurance market. That being so, the most inclusive definition of health care providers should be used.
- d) The substantive and procedural tort reforms will affect recipients and participants in health care delivery in all health care provider categories. The Commission believes it would be unwise legislation to provide for certain rules in medical negligence cases against physicians and different rules

for cases against dentists. Since all health care providers benefit from the changes, all should participate in the insurance mechanisms.

Recommendation: [No. 22]

The proposals of this Commission should inure to the benefit of, and be binding upon all licensed in the State as hospitals, as defined in AS 18.20.130 and including hospitals operated by State and political subdivisions, chiropractors, dental hygienists, physicians, osteopaths, chiropedists, nurses, opticians, pharmacists, and physical therapists, dentists, optometrists, psychologists, and pediatricists.

MEDICAL PRACTICE

A most significant impact upon the total cost of the system can be achieved by the health care providers through self-discipline and self-policing. Several specific problems were detected which make it difficult to properly achieve these results within the health care professions.

Informed Consent

Cases have been brought elsewhere against doctors, not because they performed a procedure negligently, but because they performed it without the permission of the patient, or allegedly obtained consent without properly explaining the consequences of the procedure to the patient.

Physicians frequently find it necessary to perform surgery or other procedures under circumstances where an informed consent cannot be obtained or where, because of psychological or emotional considerations it would be ill advised to be overly graphic in informing the patient of all the consequences of a needed procedure.

Recommendation: [No. 23]

There should be a legislatively prescribed procedure for informing the patient of the consequences of a procedure and obtaining the consent to perform it and also setting forth the conditions pursuant to which consent is implied or not required.

Licensing Board Authority

Discipline must be the joint responsibility of the profession and the State agency regulating the profession.

Unfortunately, under Alaska law, most medical regulatory agencies have only the authority to grant or revoke a license. Frequently, practitioners have been regarded as unable to practice in the broadest authority of their license but the agency has been reluctant to revoke the license except in the most severe circumstances.

The Commission believes that intermediate sanctions should be authorized so that discipline can be fairly administered for the protection of the public without necessary detriment to the livelihood of the practitioner.

Recommendation: [No. 24]

The appropriate licensing boards should be authorized to render disciplinary sanctions against health care providers other than license suspension. The boards should be able to reprimand, censure, place on probation, restrict practice by time, specialty, procedure or facility or to require continuing education or retraining.

Defamation Immunity

In order for the disciplinary function of the State agency, the professional association or the hospital staff committees to be effective, other professionals must be able to bring matters to the attention of the appropriate body

without fear of recrimination.

At this time, medical practitioners are reluctant to divulge information concerning observed negligence or misconduct for fear the practitioner involved will bring an action for defamation.

In addition, more information is available from health care providers than is currently made available to the licensing boards.

Recommendation: [No. 25]

The appropriate licensing board should have authority to require more relevant and more frequent reports on health care practices by and from its licensees. Persons reporting should have immunity from defamation actions based on reports made to licensing boards to officially constituted service committees of hospitals and professional health care organizations.

Funding

In order for the licensing boards to be effective, sufficient administrative and investigative staff must be employed.

Recommendation: [No. 26]

The legislature appropriate such additional funds as are needed to properly staff the health care licensing boards with investigative and administrative personnel.

Ultimately, reduced frequency of loss from negligent conduct is achieved only if the attitude of the persons involved is tuned to an awareness of the need for careful conduct.

There are available professional loss control consultants that specialize in the control of hospital malpractice losses.

Recommendation: [No. 27]

Provision should be made for more effective loss control by all health care providers but with specific attention to identified problem areas.

III. CONCLUSION

The Commission is convinced that this package of proposals when taken together is one of the most complete, feasible and marketable proposals to be considered in any state. It does no violence to the legitimate rights of persons injured as a result of negligent conduct. It removes some inequities.

It costs nothing of the State and, in fact, may result in savings in judicial expenditures, unless the legislature should elect to partially fund the late claims fund in which case there would be expense to the State to that extent. It preserves the role of the free enterprise system as a primary provider of protection.

This set of recommendations answers all of the serious legitimate objections to the present system raised by insurers. It meets the objective of the Commission by making the exposures controllable and thus actuarially predictable and controls ultimate total cost.

The Commission was made aware of the fact that the proposals of other states have not brought immediate insurance availability.

Changes to the tort system which seriously impair due process or a person's right to full recovery have been challenged as unconstitutional and insurance carriers have adopted a "wait and see" attitude.

As the Commission worked on developing a solution, contact was made with carriers to determine if they would provide the indemnity. Attached as Exhibit 10 is a letter from one carrier which is giving serious consideration

to providing the coverage. When the program becomes law, negotiations will be open to all carriers and brokers to submit proposals. The attached letter, however, demonstrates the practical feasibility of these recommendations.

The Commission finally recommends that to implement these proposals the following steps be taken:

1. The Supreme Court of the State of Alaska consider enacting rules implementing the recommendation to establish the expert medical panel.
2. The legislature enact the legislative proposal which this Commission will provide and which implements all of these recommendations.
3. The legislature, by Concurrent Resolution, place on the ballot for the general election in 1976 the recommended constitutional amendment.

GLOSSARY

Claims-made form

A policy of insurance that covers only those claims which are reported to the insurer during the policy period and which arise out of incidents occurring after the issuance of the first policy with that insurer. Claims arising out of incidents occurring during the policy period but reported after expiration are not covered.

Comparative Negligence

A rule of law which requires reduction of an award to an insured plaintiff against a negligent party if the plaintiff is also negligent in proportion to the degree of plaintiff's negligence.

Contributory Negligence

A rule of law which requires denial of an award to an injured plaintiff against a negligent party if the plaintiff is negligent to any degree.

Discovery

Procedures instituted by the parties to litigation after filing an action and prior to trial of an information gathering nature which enables the parties to elicit and evaluate all testimony and data that might become evidence in the trial.

Tail

The period of exposure to liability which exists between the date of an incident which could give rise to liability and the last date on which the fact of liability can be adjudged.

EXHIBITS

1 IN THE SENATE

BY THE FREE CONFERENCE COMMITTEE

2 FREE CONFERENCE CS FOR HOUSE CS FOR SENATE BILL NO. 361

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 NINTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act concerning health care liability insurance; and
7 providing for an effective date.

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 21 is amended by adding a new chapter to read:

10 CHAPTER 67. HEALTH CARE LIABILITY UNDERWRITING ASSOCIATION.

11 Sec. 21.67.010. JOINT UNDERWRITING ASSOCIATION. The director of
12 the division of insurance shall establish by regulation a joint under-
13 writing association to provide health care liability insurance to health
14 care providers in the state on a self-supporting basis. All insurers who
15 are authorized to write and are engaged in writing casualty or disability
16 insurance in the state on a direct basis, and all insurers who are
17 authorized to issue and are issuing subscriber's contracts in the state
18 on a direct basis, shall be members, (except that any disability insurer
19 shall be exempted by the director of the division of insurance upon a
20 showing that such insurer is prohibited by charter or by any law of the
21 United States or any state from writing casualty insurance) Membership
22 in the association is a condition of transacting insurance business in
23 the state.

24 Sec. 21.67.020. PARTICIPATION IN ASSOCIATION, DIRECTORS. (a)

25 Each member participates in the writing of policies, expenses, profits
26 and losses of the association in the proportion of the net direct premi-
27 ums written the preceding calendar year in the state by each member,
28 excluding the premiums attributable to the operation of the association,
29 to the aggregate net direct premiums written in the state by all members

1 of the association in the preceding calendar year. Each member's parti-
2 cipation in the association is determined annually on the basis of the
3 annual statements filed by the member with the division of insurance.

4 (b) The association shall be governed by a board of three
5 directors, who are elected by cumulative voting of the members of the
6 association; the votes are weighted according to each member's partici-
7 pation the year of the election. The directors serve terms of two
8 years. The directors on the first board shall be elected at a meeting
9 of members at a time and place designated by the director of insurance.

10 Sec. 21.67.030. POWERS AND DUTIES OF ASSOCIATION. The association
11 may

12 (1) issue or authorize the issuance of policies of insurance
13 to applicants;

14 (2) underwrite the insurance policies issued and adjust and
15 pay losses on the policies;

16 (3) accept and cede reinsurance;

17 (4) appoint, with the permission of the director of insurance,
18 service companies to perform its duties under this chapter; and

19 (5) adopt regulations, subject to approval by the director of
20 insurance, necessary for carrying out the provisions of this chapter.

21 Sec. 21.67.040. OPERATING PLAN. (a) The association shall
22 develop an operating plan to carry out the provisions of this chapter,
23 which is subject to the approval of the director of insurance. In
24 developing the plan the association shall receive input from health care
25 providers in the state and from representatives of the public.

26 (b) The operating plan shall provide for fair, prompt, and eco-
27 nomically self-supporting health care liability insurance and shall
28 include

29 (1) a preliminary assessment to all members for the expenses

1 necessary to begin operation;

2 (2) underwriting standards;

3 (3) appointment of servicing carriers;

4 (4) rating plans and classifications established on an actu-
5 arily sound basis and calculated to be self supporting;

6 (5) other provisions found necessary by the association.

7 (c) The association shall submit the operating plan to the director
8 of insurance for approval within 60 days after the director of insurance
9 establishes the association under sec. 10 of this chapter.

10 (d) The operating plan may be revised by an affirmative vote of a
11 majority of the directors and concurrence of the director of insurance.

12 Sec. 21.67.050. PROFITS AND DEFICITS. (a) Profits made by the
13 association may be added to the reserves of the association.

14 (b) A deficit sustained by the association in any one year shall
15 be recouped by rate increases applicable prospectively or offset against
16 the tax on total direct premiums specified in AS 21.09.210 if the offset
17 is approved by the director of insurance after determining that it is in
18 the best interest of the state and the persons intended to be benefited
19 by this chapter.

20 Sec. 21.67.060. ANNUAL STATEMENTS. The association shall file an
21 annual statement to the director of insurance before March 16 reporting
22 its operations of the preceding year.

23 Sec. 21.67.070. PERSONS COVERED. (a) Any health care provider
24 licensed by the appropriate licensing agency of the state may apply to
25 the association for health care liability insurance.

26 (b) If the applicant meets the underwriting standards of the asso-
27 ciation as provided in the operating plan and there is no unpaid, uncon-
28 tested premium due from the applicant for prior insurance, the associa-
29 tion on receipt of the premium shall issue or cause to be issued a

1 policy of health care liability insurance for a term of one year.

2 (c) In no event may the association deny insurance to a health
3 care provider without the concurrence of the director of the division of
4 insurance.

5 Sec. 21.67.080. HEALTH CARE LIABILITY POLICIES. (a) The associ-
6 ation shall offer policies on both a claims made and occurrence basis.

7 (b) Each policy issued by the association shall provide minimum
8 coverage to the insured in an amount of not less than \$100,000 for each
9 occurrence and \$300,000 for all occurrences in any one policy year for
10 the protection of persons who are legally entitled to recover damages
11 from the insured for errors, omissions or neglect in the performance of
12 the insured's professional services. The association may establish
13 minimum levels of coverage higher than these limits for professional
14 practice involving a high degree of risk.

15 (c) No policy issued on behalf of the association may be cancelled
16 during the term of coverage without the concurrence of the director of
17 the division of insurance.

18 Sec. 21.67.090. APPEALS AND JUDICIAL REVIEW. (a) An applicant to
19 the association, an insured under this chapter, or a member may appeal
20 to the director of insurance within 30 days of any ruling, decision, or
21 action by or on behalf of the association.

22 (b) All orders of the director of insurance under this chapter are
23 subject to judicial review.

24 Sec. 21.67.100. DEFINITIONS. In this chapter

25 (1) "association" means the underwriting group established
26 under the provisions of this chapter;

27 (2) "casualty insurance" means casualty insurance as defined
28 in AS 21.12.070;

29 (3) "director" means a member of the board of directors of

1 the association;

2 (4) "director of insurance" means the director of the division
3 of insurance in the Department of Commerce;

4 (5) "disability insurance" means disability insurance as
5 defined in AS 21.12.050;

6 (6) "health care liability insurance" means insurance against
7 the legal liability of the insured for loss, damage, or expense incident
8 to a claim arising out of the death or injury of a person as a result of
9 negligence in rendering professional service by a health care provider;

10 (7) "health care provider" means a physician licensed under
11 AS 08.64, a nurse licensed under AS 08.68, an institution licensed under
12 AS 18.20, and a dentist licensed under AS 08.36;

13 (8) "net direct premiums" means gross direct premiums written
14 on casualty and disability insurance less return premiums or the unused
15 or unabsorbed portions of premium deposits; .

16 (9) "subscriber's contract" means subscriber's contract as
17 defined in AS 21.87.330(6).

18 * Sec. 2. This Act expires on April 1, 1977.

19 * Sec. 3. This Act takes effect immediately in accordance with AS 01.10.-
20 070(c).

* July 2, 1975

The Honorable Chancy Croft
President of the Senate
Alaska State Legislature
Juneau, Alaska 99811

Dear Mr. President:

Although I am convinced there is a need to rewrite the Alaska Statutes dealing with medical malpractice insurance, I must veto Free Conference Committee Substitute for House Committee Substitute for Senate Bill 361, "An Act relating to health care liability insurance". In establishing a new method, wherein related medical agents and organizations may be protected in their business through insurance programs, the bill has, in my opinion and in the opinion of many others, fallen far short of yielding an adequate solution to the problem.

Only recently has the extensive outcry from members of the general and professional public been raised in opposition to the bill. In fact, there has been virtually no support of the bill from those most directly affected by its enactment. Dentists, insurance companies and hospitals have all voiced strong opposition to the bill for a number of reasons and some doctors have evidenced misgivings with the bill. Physicians do not consider the bill to be a solution to their problems and yet, they are vitally interested in corrective legislation.

As the bill was hastily passed by the Legislature (in fact, it had 15 separate legislative actions within a period of less than 36 hours), public input to the legislation was limited.

First, and most critical, is the last minute inclusion of the health care service organizations like Blue Cross as a participant in the joint underwriting association created by the legislation. The coverage to be provided by the joint underwriting association is casualty insurance; Blue Cross cannot write or reinsure this type of insurance because of its charter and because of the fact its home state laws do not permit it to do so. The legislation further allows a disability insurer in a similar situation to be exempt from participation. However, this bill appears to be worded in a way to deny such exemption to Blue Cross. An official of Blue Cross has publicly stated that he seriously questions the ability of Blue Cross to continue operation in Alaska should the bill become law. Currently, Blue Cross provides health coverage for about 60,000 residents of Alaska. If Blue Cross were forced to operate in violation of its charter and at substantially increased costs to its subscribers.

Second, when health maintenance organizations are formed, they must do so under the same chapter under which Blue Cross operates. Should this bill become law, it would act as a severe deterrent to the establishment of such health maintenance organizations.

Third, the legislation provides an expiration date of April 1, 1977. This section causes considerable concern due to the fact that one of the major difficulties with such insurance has been delayed discovery of claims, often several years after policies have been written. In fact, I understand that most claims would not be discovered until long after April 1, 1977.

Fourth, there is a legitimate concern that the limits of liability required by the legislation may be insufficient as primary coverage to make excess coverage from other sources available to the users of the joint underwriting association. This could, in effect, place a \$100,000 limit of recovery on medical malpractice cases.

Fifth, the legislation requires that rating plans and classifications be established on an actuarially sound basis and that they be self supporting. Since Alaska has a relatively small health care population, it has an insufficient number of policies over which it may spread the expenses of the proposed joint underwriting association. Hence, it appears probable that the insurance rates would soar.

Because of these major considerations and other attendant minor considerations, I will, within 15 days, be appointing a committee to develop a thoroughly comprehensive package of legislation to be introduced during the next session.

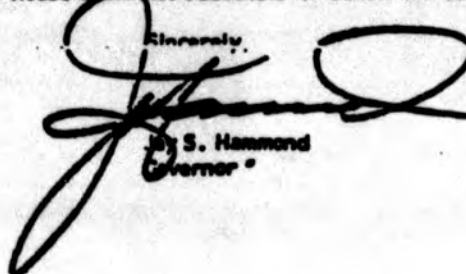
As President of the Senate, you are invited to designate one senator for appointment to the legislation drafting committee.

It is evident that the problem cannot be solved by a single bill. In Nevada, a highly workable program was developed but it required separate pieces of legislation. In California, an entire Special Session of the legislature was devoted to such insurance problems. Through this committee, I intend to appoint a team of qualified professionals as well as concerned consumers to solicit input from all those affected by such legislation. The committee's main charge will be to write a practical, workable package of health care liability insurance and deliver it to me by November 1, 1975. The committee's executive secretary will be supplied by the Commissioner of Commerce, who is preparing basic background information packages for the committee members (including copies of legislation from other states). Other staff members from the Department of Law and the Department of Health and Social Services will also be available.

I sincerely hope that there will be no need to call a Special Session of the Legislature. However, should a crisis occur, that is, should the general public be seriously jeopardized through cancellation of insurance, a strike, or any similar calamity, I will strongly consider calling the Legislature into session. To further preclude such an unwanted act, I have urged all those involved, including doctors, hospitals, insurance companies, etc., to work closely, and with as much advance notice as they are afforded, in preventing any changes in insurance coverages that would adversely affect the public and the insured, during this interim period.

Therefore, for the reasons discussed, I have vetoed Free Conference Committee Substitute for House Committee Substitute for Senate Bill 351.

Sincerely,



Jay S. Hammond
Governor

SCHEDULE OF MEETINGS

July 28, 1975	Boney Court Building, Anchorage
July 29, 1975	Boney Court Building, Anchorage
July 30, 1975	Boney Court Building, Anchorage
August 5, 1975	Boney Court Building, Anchorage
August 6, 1975	Boney Court Building, Anchorage
August 7, 1975	Boney Court Building, Anchorage
August 8, 1975	Boney Court Building, Anchorage
August 14, 1975	Boney Court Building, Anchorage
August 15, 1975	Borough Assembly Room, Anchorage
August 16, 1975	Boney Court Building, Anchorage
August 17, 1975	Boney Court Building, Anchorage
August 25, 1975	State Office Building, Juneau
August 26, 1975	State Office Building, Juneau
August 27, 1975	State Office Building, Juneau
September 3, 1975	Loussac Library, Anchorage
September 4, 1975	Transportation Hearing Room, Anchorage
September 5, 1975	Providence Hospital, Anchorage
September 16, 1975	Borough Assembly Room, Anchorage
September 17, 1975	Borough Assembly Room, Anchorage
September 18, 1975	Borough Assembly Room, Anchorage
September 23, 1975	Boney Court Building, Anchorage
September 24, 1975	Boney Court Building, Anchorage
September 25, 1975	Boney Court Building, Anchorage
September 30, 1975	Baranof Hotel, Juneau

FUTURE MEETINGS

October 17, 1975	Boney Court Building, Anchorage
October 18, 1975	Boney Court Building, Anchorage
October 19, 1975	Boney Court Building, Anchorage

LIST OF WITNESSES

Susan Burke	Alaska Court System Representative
Dick Block	Consultant - Various Presentations
Don Koch	Alaska Division of Insurance
N. E. Segelhorst	Insurance Agent/Broker
Don Coates	Ken C. Johnson, Inc.
Jamie Love	Insurance Agent/Broker
Ken Atkinson	Dawson & Co. Inc.
Bob Nestel	Commission Member
Martin Tirador	Presentation on Claims Data
Dr. R. Wilson	Commission Member
Bob Libbey	Presentation on Attorney's Role
Dr. Green	Commission Member
Dr. Bruce Wilson	Presentation on Comp. Health Care
Dr. George Ryneer	Commission Member
Dr. Chou	Presentation on Health Care Delivery Sys.
Dr. Shafel	Commission Member
Dr. Behym	Present. on Inflation in Medicine
Dr. Von Hippel	Commission Member
Sister Josephine Patty	Present. on Statute of Limitations
Brian Saylor	Physician
Dr. Beal	Physician - Radiation Therapy
Dr. Virginia Wright	Physician
K. C. Chu	Physician - Anesthesiologist
Keith Kun Dahl	Physician
Dexter Mapel	Physician
Mike Thomas	Physician - Open Heart Surgeon
Edward Lararek	Administrator - Kodiak Island Hospital
Richard L. Stites	Health Affairs Advisor
Jane Jones	Physician - Anesthesiologist
William Walters	Physician - Psychiatrist
Edgar Paul Boyco	Restaurant Owner
Grant Hubbard	Prospective Medical Student
James Delaney	Insurance Agent/Broker
Arne Werchick	March & McLennan
	Attorney
	Representing American Insurance Assoc.:
	Insurance Services Offices Rep.
	Woodside East
	Attorney
	Insurance Broker, Shann-Morahan
	Attorney
	Calif. Firm of Werchick & Werchick

Susan Overby
Tony McFarley
Ashford B. Kelly
Ava McGee
Donna Jean Lewis
Carolyn Vic
Mr. Clare Thompson
Joe Josephson ✓
Richard Garnett
Fran Olmer
Dr. Southerland

Avrum Gross
Art Peterson
Art Snowden
Dr. Gary Hedges
Bernard P. Kelly

Attorney
Attorney
Governors Office
Dentist
Alaska Dental Society President
Attorney General
Assistant Attorney General
Alaska Court System
Physician - Surgeon
Attorney

LIST OF MATERIAL REVIEWED

**HEW REPORT (Report of the secretary's commission on
Medical Malpractice)**

LEGISLATION FROM

Arizona
California
Florida
Indiana
Massachusetts
Michigan
Nevada
New York
Ohio
Oregon
Texas

LEGISLATIVE PROPOSALS FROM

Alaska
Arne Werchick
St. Paul Insurance Companies
Alaska State Medical Association
National Association of Independent Insurers

POSITION PAPERS FROM

American Mutual Insurance Alliance
Defense Research Institute
Insurance Backgrounder - State Farm Insurance Companies
Insurance Information Institute
Insurance Services Office
Ohio Director of Insurance - White Paper
Morahan
Underwriters Report

RESEARCH BRIEFS

American Hospital Association
Council of State Governments
Medical Adversity Insurance - No Fault
Data Of Medical Economics
Dexter Mapel Presentation

LEGISLATIVE CRITIQUES

University of California - San Francisco
Medical Liability Commission (Chicago)
American Insurance Association Comparison Charts

SPECIAL EDITIONS OF

Trial Magazine February - March 1970
Trail Magazine May - June 1975
Malpractice In Focus, An American Medical Association
Source Document
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REPORT ON ALASKA MEDICAL MALPRACTICE SITUATION -
January '75, Alaska Division of Insurance

INSURANCE POLICY FORMS

Shann Morahan - Claims Made
Lloyds of London - Claims Made
Standard - Occurrence

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND
GOVERNOR

POUCH B - JUNEAU 99811

July 30, 1975

The Honorable Jay S. Hammond
Governor
State of Alaska
Pouch A
Juneau, Alaska 99811

Dear Governor Hammond:

On this day, the Commission on Medical Malpractice Insurance which you appointed to study the current availability of medical malpractice insurance for the doctors and hospitals in this State has completed three full days of public hearings in the State Court House in Anchorage. Because the Commission is of the view that the situation is both vitally important for health care in this State and because certain doctors have an urgent need for an immediate solution, this interim report is indicated.

The Commission has heard testimony from the leading physicians, surgeons, medical specialists in this State, insurance brokers, insurance company executives and attorneys. All the members of the Commission have all contributed valuable information. From the testimony taken so far, the following, preliminary conclusions can be stated:

1. There is a real and serious question of the actual availability of adequate insurance coverage for doctors in this State.
 - a. There are essentially four sources for this coverage:
 - i. Continental Insurance Company
 - ii. Shand, Morahan Underwriters
 - iii. Lloyds of London
 - iv. There are limited national specialities association policies which are decreasing in numbers.

The Honorable
Jay S. Hammond

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July 30, 1975

- b.
 - i. Continental Insurance will not accept new risks.
 - ii. Shand, Morahan provides only a claim made form.
 - iii. Lloyds has indicated its intention of withdrawing completely from the market.
 - iv. A search of brokers has turned up no additional potential market sources.
 - c. The claims made form provides a type of coverage which may be too restrictive to properly protect the doctors over the full course of their professional career.
2. The exposures to liability are less susceptible to predictable measurement.
- a. Society may be increasingly litigation conscious.
 - b. Medical procedures are far more complex and involve inherent risks.
 - c. Many types of treatment, result in detrimental effects apparent only many years after the treatment.
 - d. The current law presents questions as to the definite cutoff of liability regarding time.
3. The matter is extremely complex and does not lend itself to an easy solution.
- a. Further statistical information is required: Statistics as to number, amount and character of claims filed against doctors must be developed.
 - b. Comparison of insurance rates:
 - To claims
 - To other states
 - To other professions
 - To inflationmust be studied.
- Actual evaluation of cost savings from proposed law changes must be studied.
- c. It is expected that whatever permanent solution is proposed will require legislation. There are serious questions of constitutionality and public policy that must be considered as to each presently discussed possible solution.
 - d. Much of the information necessary to properly evaluate rates, underwriting considerations and claim costs must come from out of state.

The Honorable
Jay S. Hammond

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July 30, 1975

4. The problem has three aspects:
 - a. The threat of unavailability of insurance for doctors is immediate in that certain doctor's coverage with Lloyds expires within a few days.
 - b. The matter must be addressed with the hope of finding a long range solution that will allow insurance carriers to provide a continuing and stable market.
 - c. The public may be adversely impacted by the resultant curtailment of medical services and increased costs.
5. The Commission concluded these first sessions with a resolve to continue studying the matter on an urgency basis. An agenda which includes arriving at a permanent solution has been agreed upon, the Commission will meet next Tuesday, Wednesday and Thursday in Anchorage.
6. In view of the progress made by this Commission, its members have unanimously urged all interested parties to take no precipitous action which would aggravate the already critical nature of the matter so only as this Commission continues its conscientious effort towards a permanent solution.
7. The Commission fully appreciates and understands that any delay in finding a solution causes an undue and very large burden on the practitioners and the public. As to the practitioners who continue normal and good medical service to the public we feel that the public should fully understand the grave risk many of the practitioners run in the current insurance - or lack of it - environment. The public and the government should empathize with this act of genuine public service displayed by practitioners who continue virtually unprotected in a manner deemed appropriate and desirable by all.

Sincerely,


Larghorne A. Motley
Commissioner

cc: Commission members

MARSH & McLENNAN

August 12, 1975

TO WHOM IT MAY CONCERN, GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE
INSURANCE AND ALASKA STATE MEDICAL ASSOCIATION

Gentlemen:

Marsh & Mc Lennan, Inc. of Alaska acting as Broker of Record for the
Alaska State Medical Association and as administrator in Alaska of
Shand, Morahan & Co. - Mutual Fire, Marine & Inland Insurance Company's
Medical Malpractice Program agree to the following:

1. That the Shand, Morahan & Co. Program will provide the
as follows:
 - a. On new policies issued in the Shand, Morahan & Co.
Program where the physician has previously been
insured with Lloyds of London (regardless of syndicate),
we will contractually guarantee that at the end of the
Lloyds discovery period the Mutual Fire contract will be
endorsed to cover incidents which may have occurred
during the period the London contract was in force but
had not been reported at the end of the Lloyds discovery
period. This letter will serve as such contract guarantee
as the actual endorsement to the Mutual Fire contract will
not be added until the Lloyds discovery period ends.
2. We will agree that we will not cancel contracts put into force
except:
 - a. non payment of premium
 - b. for discovery by the carrier that material statements
in the application are false or that during the term of
the policy there has been a change in medical specialty
from that designated by the physician on his application
or physician has been subject to disciplinary proceedings,
committed or treated as provided in Question 18 of the
application.
3. We will agree to continue underwriting and providing as
previously outlined to anniversary date of original agreement
of program; i.e. April 1, 1976, assuming that Marsh & Mc Lennan,
Inc. of Alaska is maintained as Broker for ASMA until that date,
and providing the ASMA takes no affirmative action to misrepresent
the terms and conditions of the program and the policies can be
issued.

MARSH & MCLENNAN

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4. All persons taking this policy must agree to a minimum earned premium on each policy issued of 10% of the annual premium if cancelled by the insured.

MARSH & MCLENNAN, INC. OF ALASKA


By: Dexter M. Mapel
Account Executive


By: R. L. Snitil
Assistant Vice President-Manager

On this 12th of August, 1975, before me, the undersigned, a Notary Public in and for the State of Alaska, duly commissioned and sworn, personally appeared Dexter M. Mapel and R. L. Snitil to be representatives of Marsh & McLennan, Inc. of Alaska.


Notary Public in and for State of Alaska

My Commission Expires
September 13, 1976

MEDICAL MALPRACTICE INSURANCE COMMISSION

August 8, 1975

Jay Hammond
Governor
State Capitol Building
Juneau, AK 99801

Dear Governor Hammond:

The Medical Malpractice Insurance Commission has spent over 45 hours in deliberations, hearing approximately 40 persons testify, received over 90 proposals from the general public, interested local members of the medical, insurance and legal professions and experts invited from other states.

The Commission believes that the magnitude of the long term problem precludes any acceptable comprehensive solution at this stage of our proceedings. Nonetheless, the Commission well recognizes the immediacy of the problem in view of the sharply curtailed health care in Alaskan communities and its attendant long range implications on future availability of medical care to Alaskans. Thus, through the efforts of interested parties, Commission members and the specific insurance brokers and companies involved, an improved insurance program has been made available to the majority of the doctors in the State. The modifications, agreed to by the involved broker, were among the specific items relayed to the Commission as being of most serious concern to the doctors. Specifically, the broker for the Alaska State Medical Association Group Medical Malpractice Insurance Program has agreed to confirm, subject to the approval of the underwriter, Shand, Morahan & Co., that policies issued pursuant to such program will not be cancelled, that they will guarantee the availability of retroactive protection upon expiration of the three-year term protection on Lloyds of London policies provided the doctors had continuous Lloyds of London protection prior to taking the Shand, Morahan & Co. Program and agreed to continuity of the Program through April 1, 1976, provided Marsh & McLennan remains broker of record for the Association. Final approval from Shand, Morahan & Co. is expected prior to August 13, 1975.

The Commission, by unanimous vote of the members present, endorsed the program as a first and interim step, even though

Governor Jay Hammond

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August 8, 1975

the Commission recognizes that this Program does not fully remove the risks or problems faced by all concerned parties and will continue attempts to close gaps in coverage of this interim system.

It is hoped that all involved will see this as a positive step and that the physicians will return to their practices. Meanwhile, the Commission pledges to work toward a system providing a suitable climate for efficient, high-quality medical care at less than prohibited cost.

The Commission plans to meet next week to address specific solutions.

Sincerely,

Langhorne A. Motley, Chairman
MEDICAL MALPRACTICE INSURANCE COMMISSION

AM:kek

Malpractice cases filed in Alaska

(By 1973 Anchorage Daily News)

DATE	TYPE OF PRACTICE	ALLEGED COMPLAINT	REPORTED SETTLEMENT
1957	Internal medicine	Error in pharmacy prescription.	\$2,500, out of court
1957	Surgery	and complications after surgery. Settlement for patient. Case refilled in 1960 with new settlement for patient.	\$410,000, out of court
1958	Surgery	Hip pin punctured bladder.	\$100,000+, out of court
1959	Neurosurgery	Complication following angiogram (a process of injecting dye into blood vessels to show on X-Rays).	\$30,000, out of court
1959	Surgery	Infection following surgery.	\$100,000, out of court
1959	Ob/gyn	Complaint following hysterectomy.	In favor of the doctor..
1959	Surgery	Complications following surgery on hip. Hospital, doctor were sued for loss of consortium (sexual relations).	\$100,000+, out of court.
1961	Surgery	Pin driven through hip socket into abdomen, damaged pin left in body. Jury verdict for doctor. Case appealed to Alaska Court of Appeals and court against doctor.	\$30,000, jury trial; case appealed
1962	Ob/gyn	Complications after birth of twins.	\$1,000, out of court.
1962	Orthopedic surgery	Complaints after surgery.	\$3,500, out of court
1963	General practice	Excessive dose of antibiotics.	Out of court, award to patient
1963	Surgery	Complications after thyroidectomy. Case heard by judge who found doctor not liable. Appealed to Supreme Court and sent back to lower court where it was decided against doctor.	\$60,000, before a judge
1964	General practice	Bridgework destroyed during anesthesia.	\$1050, out of court
1965	General practice	Patient burned during heat therapy.	\$20,000, jury trial
1965	General practice	Death during surgery for ulcer.	\$40,000, out of court
1966	Orthopedic surgery	Improper healing of fractured hand and arm. Settled out of court, refilled in 1971, dismissed.	In favor of the doctor, out of court
1966	Orthopedic surgery	Hand crippled after surgery.	\$7,000, out of court
1966	Surgery	Complications following Cesarean section.	Dismissed when patient's attorney did not appear.

1967	Neurosurgeon	Death in 1965. Patient entered federal hospital complaining of headache, hypertension. Heard by judge in federal court. Decision: August, 1972.	\$8,000, paid by federal government; heard before judge.
1967	Orthopedic surgery	Death. Patient injured in accident; died 17 days after admitted to hospital.	In favor of the doctor, out of court
1967	Internal medicine	Failure to diagnose and treat cancer.	Dismissed in 1959 when patient's attorneys withdrew.
1967	Internal medicine	Loss of leg.	\$165,000, jury trial
1967	Ob/gyn	One-day old baby contracted spinal meningitis. Three-week jury trial.	For the doctor, jury trial.
1968	Surgery	Injuries during surgery.	Out of court
1968	Orthopedic surgery	Hand crippled after surgery for broken wrist.	Dismissed when patient failed to return to Alaska to post bond
1968	Surgery	Dislocated ankle.	In favor of the doctor
1970	Pediatrics	Premature baby born 1968. Case filed in 1970. Jury trial in 1972 declared doctor not liable. Out of state parents appealed case to Supreme Court.	Jury verdict for the doctor, appealed to Alaska Supreme Court, pending.
1970	Ob/gyn	Bladder punctured during hysterectomy	\$28,000, out of court
1970	Pediatrics	Suit filed against doctor's estate.	Out of court settlement
1970	General medicine	Misdiagnosis caused patient to sell business, leave state.	\$7,000, out of court
1970	Oral surgery	Death. Patient died during anesthesia for oral surgery.	\$180,000, out of court
1970	General medicine	Doctor mistakenly reported venereal disease.	In favor of the doctor, out of court
1971	Ob/gyn	Patient still pregnant after legal abortion.	\$3,000, out of court
1971	Orthopedic surgery	Complaints after surgery.	No settlement; patient left state
1971	General medicine	Death. Patient died after inhaling polyurethane. Settlement award split among doctor, medical laboratory and paint manufacturing company.	\$150,000, before a judge
1972	Surgery	Fracture of cervical spine; paral. sis. No suit filed.	\$476,000
1972	General medicine	Failure to follow patient progress after administration of drug.	\$14,000
1973	Surgery	Wife conceived after husband's vasectomy; surgery performed in 1970.	\$7,500, out of court
1974	Oral surgery	Damage to facial nerve.	\$19,000
1974	Orthopedic surgery	Complaints following surgery for varicose veins.	"Nominal," out of court
1974	Physician	Umbilical hernia.	\$100,000, out of court

PENDING SUITS IN ALASKA

Orthopedic surgery: 1
Ob/gyn: 7
Surgery: 5 (two deaths)
Radio/gy: 1

Pathology: 1 (one death)
General medicine: 4
Anesthesiology: 1
Hospitals: 3

Malpractice case list expanded

DATE	TYPE OF PRACTICE	ALLEGED COMPLAINT	REPORTED SETTLEMENT
1957	surgeon	sponge left in patient	\$100,000 out of court
1958	psychiatrist	unknown	unknown
1960	surgeon	surgery performed on wrong rib; more surgery required	out of court
1961	surgeon	doctor did not cure patient	attorney cannot remember settlement out of court
1961	orthopedic surgeon	hip pin installed negligently	? out of court
1962	dental	plaintiff's arm broken during dental treatment	? out of court
1962	surgeon	patient fell out of hospital bed	"very small" out of court
1962	general practitioner	negligent diagnosis	about \$20,000 out of court
1962	surgeon	injuries during anesthesia	\$20,000
1962	surgeon	death, surgery conducted carelessly.	? out of court
1962	surgeon	Baby stillborn	? out of court
1963	physician	negligent treatment	settlement for the doctor out of court
1963	dental	five weeks of pain and suffering after dental treatment	"very small" out of court
1964	physician	complications during local anesthesia	\$100,000
1964	oral surgery	patient died in dental chair	\$70,000 out of court
1965	surgeon	negligence	\$3,545 jury trial
1966	radiology	injury from excess radiation	\$80,000
1967	obstetrics	death during childbirth	doctor's estate sued "nominal"
1969	surgeon	performed surgery without patient's consent	"small" out of court
1970	surgeon	wife conceived after husband's vasectomy	\$750 out of court
1971	surgeon	death during tracheotomy	\$80,000 out of court
1971	neurosurgeon	negligent examination, follow-up	\$300,000 jury trial
1972	gynecologist	Negligent administration of an injection.	\$6,000 out of court
1971	surgeon	Death during anesthesia	\$25,000 out of court
1971	physician	Patient died in jail	\$7,500

COMPUTATION OF PREMIUM

MARSH & McLENNAN PROGRAM

ASSUMING A HIGHEST RATE CLASS PHYSICIAN TERMINATES PRACTICE

Claims made coverage primary limit 200/600 highest rating classification	\$12,080.
Excess coverage to 1,000,000 @ 50% of primary premium *	\$6,040.
Total one year premium	\$18,120.
If the practitioner elected to terminate practice, retire or if the insurance program is terminated, coverage for claims made during a three year discovery period following the last period of primary coverage - 150% of the one year premium	
	\$27,180.
Total one year premium with 3 years discovery	\$45,300.

- * The Commission has subsequently learned that the excess coverage cost is 75% of primary resulting in proportionately higher total costs.



Alaska Pacific Assurance Company

1007 W. THIRD AVE.
ANCHORAGE, ALASKA 99501

August 25, 1975

Medical Malpractice Commission
State of Alaska
C/O Department of Commerce
Pouch D
Juneau, Alaska 99811

ATTN: Richard L. Block

Gentlemen:

This letter is for the purpose of expressing an interest in and some comments regarding a concept being considered by you as a potential device for resolving the programs surrounding the present malpractice situation.

A prerequisite to the plan surrounding the creation of a professional indemnity corporation and the attendant insurance approach to the problem would be the need for certain legislative changes in the existing legal system.

A. Revised Statute of Limitations and Discovery .

We feel that there should be a two or three year statute of limitations and a one year limit on discovery . In discussing a concept it's probably premature to get into specifics. However, in order to convert to this type of program, some device would have to be developed to cover incidents earlier than the three years or four years. In this area, I believe a solution is being explored which would provide for the creation of an indemnity fund, partially by contributions from the medical care providers and partially by the State out of the General Fund.

B. Legislation should provide for some limit on general damages.



Alaska Pacific Assurance Company

Medical Malpractice Commission
August 25, 1975
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C. The broadest possible utilization of collateral sources and the denial of the right of subrogation.

D. Separation of legal fees from awards.

Earlier this month, ALPAC's Vice President of Claims and a representative from our legal firm attended a two-day seminar in San Francisco sponsored by the Professional Lawyers Institute on medical malpractice. This was one of the topics discussed. Rather than the contingency fee situation, to have the legal fees determined by the court or by the arbitration panel.

E. A device for binding arbitration.

Although not requiring legislation, there are a couple of other areas that should be considered in this concept.

1. A screening panel of physicians that would have a non-binding but evidence developing effect on subsequent trials.
2. An improved disciplinary authority, either by the proposed indemnity corporation, or the licensing authority, over medical care providers.

The concept calls for the creation of professional indemnity corporation that would provide a mandatory and exclusive insurance program for all medical care providers. This, more than perhaps any other factor, would make the insurance program viable.

The two most fundamental principles of insurance are the law of large numbers and the spread of risk doctrine. The law of large numbers cannot apply to this situation, but putting the program into one facility maximizes the spread of risk doctrine.



Alaska Pacific Assurance Company

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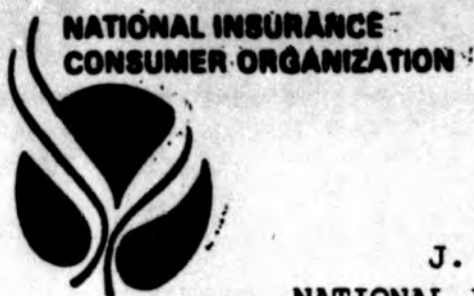
At this point, there is a parallel between the concept being discussed and the insurance program developed for the Alaska Loggers Association. From a workmen's compensation insurance point of view, this is the most hazardous industry in Alaska. Yet, because membership in the association is a prerequisite to insurance, they each enjoy their own individual rates based on their own individual experience; yet collectively their rate is 55% less than the published rate. As the commission explores this concept more in detail, ALPAC would be most interested in working with the commission, exploring such details as to whether the professional indemnity corporation should be established as a casualty insurance carrier and utilize an underwriting manager; whether it should be a pool concept of carriers interested in the project; or whether a servicing carrier supported by its own reinsurance should be the concept; or whatever else might be tailor made from the insurance side to assist.

In summary, this is a viable program and ALPAC would be interested in pursuing it more in detail.

Yours very truly,


John H. Hale
President

JHH/kw



Statement of
J. ~~ROBERT~~ HUNTER, PRESIDENT
NATIONAL INSURANCE CONSUMER ORGANIZATION

Before: The Joint Hearing
of the
House Labor and Commerce Committee
and the
House Judiciary Committee
of the
Alaska State Legislature

April 25, 1989

Mr. Chairman and members of the Committee, it is a great pleasure to be back in Alaska.

I have a question: Why are you still considering so-called "tort reform" when everywhere else the issue is now insurance reform and "tort reform" is a dead issue? There is a good reason for the change. Consider these facts:

*20 States, including Alaska, have sued insurers alleging collusion to create the liability insurance crisis of the mid-1980's --- the predicate for "tort reform."

*California citizens adopted Option 103, wisely recognizing the need to tame the monumental (and uncontrolled) insurance industry.

*We now know that tort reform doesn't lower insurance rates but insurance reform does!

*Key insurance reform proposals have gained widespread support (for example, the effort to repeat the anti-trust exception insurer enjoy in the McCarran-Ferguson Act is supported by both ABA's (Bar and Banker), small businesses,

121 N. Reynolds Street
Alexandria, Virginia 22314
(703) 549-8050
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of Attorneys General), AARP, all consumer groups, environmental groups, civil rights groups, the FTC and the Ford, Carter and Reagan Justice Departments).

I. FROM A CONSUMER VIEWPOINT, WHAT'S WRONG WITH TORT REFORM?

A. "Tort Reform" doesn't lower prices

Given this history, any adoption of Tort Reform without mandatory lower insurance rates is surely buying 'a pig in a poke.'

1. The Aetna and St. Paul Filings. Aetna Casualty and Surety Co. and St. Paul Fire and Marine Co. have undertaken closed claim studies purposing to demonstrate that the savings resulting from five major tort reforms enacted in Florida -- eliminating the collateral source rule, capping non-economic damages, restricting joint and several liability, limiting punitive damages, and requiring periodic payment of future economic damages -- would be negligible. See attachments 1A and 1B.
2. The State Farm letter. State Farm has corroborated the Aetna and St. Paul results. In a letter to the Kansas Insurance Department State Farm concludes, on the basis of "a sampling of commercial liability claims," that the following tort reforms would bring about the following savings:
 - a. eliminating the collateral source rule -- "about 1%";
 - b. non-economic cap -- "will not exceed 1%";
 - c. restricting joint and several liability -- "in our sample of liability claims, no claim was found that would have been affected by the joint and several restriction";
 - d. limiting punitive damages -- "in our sample, no punitive damage awards were found";
 - e. alternative payment of future economic losses - savings "would be negligible."

State Farm also emphasized that "it will probably be several

years before any effect from tort reform legislation can be expected to influence our experience." See Attachment 2.

3. The Florida Insurance Department data. 277 rate filings purporting to calculate the effect of the Florida tort reforms are on file with the Florida Insurance Department. 175, or 63%, showed no effect from the Florida tort changes, and the average reduction in all 277 filings was 1.2%. See Attachment 3. By way of contrast, insurance companies increased premiums in Florida by 62% in 1985, according to NAIC data, and by a similar amount in 1986.

4. The Great American West letter. In Washington state, which enacted perhaps the most comprehensive tort reform package in the nation in 1986, Great American West, Inc. calculated that the new law would, if anything, raise insurance rates. Great American West concluded:

"It does not appear that the 'tort reform' law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the 'tort reform law.'" See Attachment 4.

5. The ISO Chief Executive Circular. Perhaps most disturbing, the Insurance Services Office has announced that it is issuing "advisory" rates that show no reduction resulting from tort reform, and has emphasized to its member companies that "any beneficial effects of tort reform cannot be quantified with any degree of accuracy" (emphasis ISO's). See Attachment 5. Yet when in 1975 New York enacted tort reform that would expand liability by replacing contributory negligence with comparative negligence, with comparative negligence, and would through raise insurance costs, ISO immediately raised its advisory rates by 5%,

and provided full actuarial justification for the increase. See Attachment 6. It is not readily apparent why ISO can tell us how much rates should rise when tort law expands, but can't tell us how much rates should fall when tort law is limited.

Whether it is good public policy to reduce insurance rates by limiting compensation to seriously injured people is a question on which reasonable minds can differ. But it is clearly not good policy to limit compensation to injury victims and get nothing in return.

B. "Tort Reform" lowers consumer rights and gives them nothing in return.

"Tort reform" takes away from the victim of negligence. It grants nothing in return for this reduction in rights. There should be a quid-pro-quo if Alaska's citizens are to be denied their rights.

C. "Tort Reform" is not based on careful analysis of need.

There have been few careful studies of how victims are treated under the current liability system to determine if there is a problem that needs fixing.

For Texas, where a closed claim study was undertaken, it showed no need for changes in the legal system

To try to find something without understanding what, if anything, is wrong with it, makes no sense.

D. "Tort Reform" lowers the deterrence effect of the legal system.

How could copying the liability of Exxon's oil transport strike you? Or Ford in building Pintos? Or A.F. Robbins in building Dalcom Shields?

America's consumers need the protection of the legal system to deter inappropriate behavior; to stop "crime in the suites."

E. The need for flexibility

People are not chattel. They are not fenders bumped or houses burned. When a drunk driver runs over a breadwinner, or a little girl, or a underwater reef, the penalty must fit the circumstances, both in terms of the victim and the wrongdoers act.

II. WHY DO CONSUMERS WANT INSURANCE REFORM?

A. Insurers are grossly inefficient

"Republican or Democrat, liberal or conservative, there is one thing we can agree on --- waste is bad, inefficiency robs us all."

Andrew Tobias
The Invisible Bankers

"Tobias says we are inefficient and he's right. We spend too much on distribution, overhead and just plain waste."

John Cox, President
Insurance Agency of North America

One of the best service auto liability insurers, USAA, delivers the product at a total overhead cost of twenty cents on the premium dollar. The average insurer requires over thirty-five cents. Prices could fall by 19% if the average insurer becomes as efficient as USAA.

B. Insurers are not well regulated.

Alaska's insurance regulation has historically been, to put it in its most favorable light, non-existent. Often bragging about the highest profits in the nation in its annual report, the Department has not historically protected consumers in this state.

When last I appeared here, I challenged then Director George by saying I doubted that the Department had ever

disapproved a rate. He responded by pointing out that he had too disapproved a rate -- an automobile rate for State Farm -- a decrease!! He said he was afraid State Farm would attract too much business if their rates went down.

How's that for consumer protection?

I don't mean to pick on Alaska, particularly State regulation generally is awful. I am encouraged by the new Director Roller. The U.S. General Accounting Office found "a lack of arms-length relationship between the regulators and the regulated" and that consumers were, generally, not protected by the state insurance departments of the nation.

C. Insurers are not fully competitive

In most states, insurers are structured comparatively. In auto insurance, for instance, 29 states have low concentration (Herfindahl-Hirschman Index below 1000), 21 are moderately concentrated (HHI between 1000 and 2000) and one, Alaska is heavily concentrated (HHI greater than 1000).

So, you have a problem with relying on competition even in the best of competitive worlds.

But insurance is hardly "the best of competitive worlds," viz:

- *it is largely exempt from anti-trust laws (Alaska exempts it from state anti-trust law and the McCarran-Ferguson Act exempts it from federal anti-trust law).

- *it is the last bastion of fair trade laws (the Alaska anti-rebate law makes it unlawful for agents to offer discounts).

- *there are prohibitions on group sales

- *insurance price and service information is hard to understand, if you can find it at all.

Combining these comparative impediments with weak regulation guarantees two things:

- inefficiency and/or
- excessive profits

D. Alaska's profits are excessive

We know insurers are inefficient so profits can be hidden. But profits are too high in Alaska. According to the National Association of Insurance commissioners, Alaska's property/casualty insurance profits are among the highest in the country.

Here are the overall profits for the last decade:

	Premium <u>Earned</u>	Operating <u>Profit</u>	Total Return <u>on Equity</u> Ø	Premium <u>Earned</u> *	Operating <u>Profit</u>	Total <u>Return on</u> <u>Equity</u>
1978	\$285 Million	6.3%	17%	\$80 Billion	5.9'l	16'l.
1979	258	9.1	23	89	4.7	14
1980	257	6.8	19	95	4.6	15
1981	264	3.5	13	97	3.3	13
1982	332	18.0	43	103	0.7	8
1983	412	4.8	17	111	-0.2	7
1984	443	3.1	14	121	-3.2	1
1985	537	-1.9	4	140	-4.1	-
1986	642	3.4	15	176	2.0	13
1987	636	7.1	23	197	3.1	15
Total	\$4,066 Million	5.4%	18%	\$1,209 Billion	1.4%	10'l.

*Source: National Association of Insurance Commissioners, Profitability by line, by state, ten most recent editions.

Ø Estimated by assuming equity to premium rates of 2:1; investment income on equity of 9% latest year decreasing by 0.5'l. by year.

And this national 10% return understates the real economics vitality of their industry. during the same 10 years, the property/casualty industry's common stock have risen by 308'l. vs. 163'l. for the NYSE Composite Index (Source: Bests' Insurance Management Regents, January 1988.

Profitability in 1987 in Alaska for Medical Malpractice was over 50'l. return on equity and for other liability was over 40%r e- turn. But this was a high profit compared to other recent years. Medical malpractice profits in Alaska mirror the national averages over a ten-year review. When the General Accounting Office discounted reserve method of measuring profits is used, the return is about 30% over 10 years. The other liability return in Alaska was lower than the national average of GAO, 26% It was about 12% a good, not excessive return (if you ignore expense inefficiencies).

In 1987, Alaska's leading writers did well, viz:

Leading Medical Malpractice Writers:

	<u>Loss Rates*</u>
1. Medical Indem. Alaska	50.8%
2. Medicine/N.S. Exch.	34.0
3. CNA	66.5
4. Health Care Indem.	56.6
5. Amer. International	53.0

A profitable loss ratio would be about 90%. This shows remarkable profits in 1987.

*Source: Best's Executive Data Service

Alaska's Leading Other Liability Writers

	<u>Incurred/Earned Less Ratio</u>
1. American International	62.9%
2. Alaska National Insurance	33.8
3. Crum & Forster	64.8
4. Nationwide	50.3
5. CNA	50.6

A loss ratio of the order of 85% should be profitable. Again, 1987 was a remarkably good year for insurers in Alaska.

1988 was better, nationally. I do not have 1988 Alaska data as yet.

III. THE SPECIFIC PROBLEM - MEDICAL MALPRACTICE FOR DOCTORS DELIVERING BABIES IN RURAL AREAS

A. A real problem

No one should minimize the serious nature of unaffordability of malpractice insurance in rural areas for doctors delivering babies. Alaska is not alone in having this problem.

B. The Medical Malpractice "Crisis" in Alaska is NOT Due to an Expensive Aggregate System Cost.

If you look at the total costs of the Medical Malpractice system in Alaska it is an inexpensive system. For example, the latest data from the National Association of Insurance Commissioners (NAIC) shows total premiums in Alaska of \$13.6 million during 1987. That's \$28.00 per person (The statistical Abstract of the United States shows 481 Thousand people in Alaska in 1984).

For perspective, the average American spends \$133f per year on tobacco products.

Another way to look at system cost is vis-a-vis total medical costs in the state. According to the Alaska Department of Health, Alaska spent \$2,763 per capita health care costs by 1.0% (\$28.00 divided by \$2,763). I dare say that if you had no system to compensate the victims of malpractice and someone offered to do it for you for a percentage this small, you'd probably grab it.

C. Allocation is the Problem.

The problem is cost allocation, not total system costs. There are only about 550 doctors in Alaska (Statistical Abstract, 1986). This drives the cost very high, to about \$25,000 per doctor on average, some of which may

be positive (because of deterrence effects), but some of which is likely inappropriate.

If you think of the medical profession as a pyramid, with the relatively many G.P.'s at the bottom and the relatively few specialists at the top, I think the problem becomes easier to visualize.

If I wake up in the morning with a bad back and go to my G.P., the likelihood of a major malpractice suit arising is negligible. But if my back is a serious medical problem, I will be referred up the specialty ladder until I get to the neurosurgeon.

At the top of the pyramid, where the number of insureds is least, the risk is greatest. Bad outcomes become more likely. The chance of lawsuit rises, and the cases are much more complex.

I believe it violates insurance spread-of-risk principles to force so much through such a narrow base. (Even though neurosurgeons net income, after med mal premiums, is excellent according to medical economics).

For one thing, why should the defense costs for the complex suits neurosurgeons win be forced to be spread through only the neurosurgeons? Why shouldn't the referring physician and the hospital granting privileges bear some of the cost of successful suits (as incentives for safer referrals/privilege granting)?

The overall system cost is reasonable in your state. Your focus should be on the allocation process, in my estimation.

IV. REINSURANCE PROBLEMS

- A. Lloyds of London, the dominant reinsurance company with approximately 25% of the world-wide market, has been wracked by scandals in recent years.

For example:

o Between 1973 and 1982, two Lloyd's underwriters, Peter Cameron-Webb and Peter Dixon, siphoned off for their own use \$55 million belonging to 1,500 Lloyd's members. Investigators say they used the money for yachts, corporate aircraft, a French orange juice company and a pornographic movie entitled "Let's Do It." see Chicago Tribune, Oct. 20, 1985, at 5; Business Week, Aug. 5, at 57.

o Many of the 1,500 swindled by Cameron-Webb and Dixon are suing Lloyds (although Parliament immunized Lloyds from lawsuits in 1982, the 1,500 are claiming that the immunity doesn't apply to events occurring before 1982). Lloyds, on the other hand, is claiming that the 1,500 owe Lloyds another \$180 million. 100 members face bankruptcy and 200 have been suspended for failing to meet Lloyds' solvency test. See Chicago Tribune, Oct. 20, 1985; Business Week, Aug. 5, 1985.

o Lloyds has grown too fast. In the last decade the number of Lloyds' members has more than tripled to 26,050. Chicago Tribune, Oct. 20, 1985. Since 1981 alone, Lloyds has added 7,000 new members, including "newly rich doctors, lawyers, accountants and rock musicians . . . lured by the hope of annual returns to members that topped 100% some years." Business Week, Aug. 5, 1985. Its total premium writing capacity rose from \$3.4 billion to \$9.4 billion. Id.

- B. In 1982, Lloyds was granted immunity from lawsuits by the British Parliament. Business Week, Aug. 5, 1985, at 58.

- C. Lloyds has threatened, coerced and intimidated both insurers and insureds -- such as states -- in order to keep insurance rates high, as the following statements indicate:

o You may recall this statement:

"If you change your tort laws in Alaska, you will have a market here when the rest of the United States will not. Lloyds is pulling out of the United States as a reinsurer -- they have already pulled out of Connecticut, New York and New Jersey

-- and they're continuing to pull out of more states."

Statement of Jeff Johnson, Partner, LeBoeuf, Lamb, Lieby and McCrae (U.S. counsel for Lloyds), at the Casualty Insurance Colloquium, Anchorage, Alaska, Sept. 17, 1985.

Alaska is not alone:

o ". . . in order to keep [Lloyds] participation on cover we had to accede to some strong suggestions from the reinsurers to beef up the rate charged to the OB's."

Statement of John Spinella, President, Medical Mutual Liability Insurance Society of Maryland, before the Governor's Task Force on Medical Malpractice, Oct. 22, 1985.

o "[reinsurance brokerage head Thomas A.] Green said that beginning in 1986, Lloyd's syndicate would 'simply not write reinsurance for the American casualty industry.'"

Journal of commerce, June 18, 1985.

o "Mr. Wakefield conceded that Lloyds cannot dictate to American regulators on Policy approval, but he wryly

said that if the new form is not approved, Lloyds will not reinsure American liability underwriters."

Journal of Commerce, July 26, 1985, citing C.T. Bowing & Co. Chief Executive Gerald Wakefield, presenting Lloyds' views to 17 insurance commissioners.

o "A Lloyd's of London delegate who flew over expressly for the [insurance commissioner's] meeting added that unless the U.S. industry was permitted to adopt the new form, the lloyds reinsurance market would discontinue backing American underwriters forthwith."

Journal of Commerce, July 27, 1985.

- D. Neither the U.S. government, the states, or the British Parliament regulate Lloyds.
- E. The British pound, which was worth \$2.80 in the mid-1960's has been worth less than half that for most of the last two years and fell to \$1.05 in February 1985. Thus, whereas Lloyds would need to pay only 10,000 pounds to satisfy a \$28,000 claim in 1963, today it must pay 20,000 pounds to satisfy the same claim and in February 1985 -- when the pressure first started to build for tort reform -- it had to pay 26,600 pounds.

V. SOLUTIONS

- A. How to Solve the Insurance Crisis -- What Alaska Should Do
 - 1. Repeal Alaska's Anti-trust Exemption
 - 2. Repeal statutes that prohibit businesses and consumers from joining together to buy insurance in groups. Today, in most states, group health and life insurance is available, but group liability insurance is illegal. If laws prohibiting such group insurance were repealed, the price of liability insurance would fall.

3. Prohibit rate increased from taking effect until such increases are approved by the insurance commission. Today, in most states, increases automatically take effect unless disapproved within a certain number of days; because the burden is on the insurance commission to disapprove a rate, and because insurance commissions do not have the staff to analyze even a fraction of rate filings, most increases automatically take effect. Shifting the burden of proof to the insurance company to demonstrate that a rate increase is justified would limit such increases.
4. Allow greater consumer representation before regulatory bodies. Typically, only regulators and insurance companies participate in rate cases. To increase citizen participation in the ratemaking process, states should authorize Citizens' Insurance Boards, groups of insurance consumers who would intervene on their own behalf. In the alternative, states could establish Offices of Public Advocates to intervene in rate cases, as New Jersey and some other states have. In New Jersey when the Public Advocate intervenes in a rate case the cost of that intervention is billed back to the insurance company seeking the rate increase, thus discouraging insurers from seeking exorbitant increases.
5. Require that insurance rates be based on experience. Because insurance companies today often lump all insureds in a category together, regardless of how often any individual insured has been sued, good risks currently subsidize bad risks. Experience rating would go a long way toward bringing down premiums for medical malpractice insurance, in which experience rating is now virtually non-existent.

6. Enact tough conflict-of-interest statutes to close the "revolving door." As the U.S. General Accounting Office has found, 50% of state regulators come from and return to the industry; the relationship between the industry and the regulators is not an arms-length relationship.
7. Require that insurance companies disclose their loss data on a line-by-line basis. Such disclosure would enable regulators to better discern whether rates are excessive, inadequate or unfairly discriminatory.
8. Establish state reinsurance programs.
9. Beef up the Insurance Department both authoritatively and with resources.
10. Repeal the state anti-rebate law.
11. Publish buyers guides with price and service information.

B. Medical Malpractice

Render the above:

1. Lessen the number of classes.
2. Let hospitals bear part of the cost for adverse procedures in the hospital. Consider channeling doctors malpractice costs through hospitals.
3. Consider a specific subsidy in rural areas for physicians consider additn a malpractice charge on all health insurance premium as a subsidy dollar base.
4. Attract more physicians to Alaska to normalize the patient/doctor ratio.

VI. WHY CONSUMERS OPPOSE HOUSE BILL NO. 166

Generally:

1. We lose rights.
2. We get nothing in return (such as a victim's reparations regime).
3. It treats us like a fender, not a person.
4. It won't work to lower rates and make insurance more available.
5. It lowers deterrence.
6. There is no study showing need for change.

It specifically has these problems, among others.:

1. Lets faulty product manufacturers or bad surgeons off the hook if six years go by before the product blows up or the sponge works its way into someone's heart.
2. Fixes the possibly real problem of collateral source in exactly the opposite (and wrong) way. While no one should collect twice for the same injury, the wrong doer should pay, not our policies. Our rate should go down, not drunk drivers. mandate subrogation and order lower health insurance rates.
3. Creates inter-family problems by limiting a baby's right to sue to two years ending special treatment for minors.
4. It limits our freedom to choose the sort of settlement we want, lump sum or structured.
5. It creates a disincentive for insurers to pay (as if they needed any more) by charging them below market interest if they delay.
6. It caps non-economic damages in wrongful death cases at a pitiful \$50,000.

VI. CONCLUSION

Alaska needs reform that works -- Alaska needs insurance reform. Like other smaller population states, large multinational insurers can hold you hostage. You may well need consider working for interstate compacts with larger states to avoid the kind of under pressure Lloyds and others have brought to bear here. And other states are moving. Almost every state has insurance reform bills before the legislature. Little New Mexico voted to repeal that state's anti-trust exemption, but the governor vetoed it under intense pressure from the insurers. Arizona has many reform bills before it. South Carolina is moving a bill. Maryland returned to prior approval. The Texas Senate late last week voted to repeal that state's anti-trust exemption. The Chairs of the U.S. Senate and House Judiciary Committees have introduced bills to end McCarran's broad anti-trust immunity.

Now is the time for insurance reform. I pledge NICO's assistance to you in achieving such real reform.

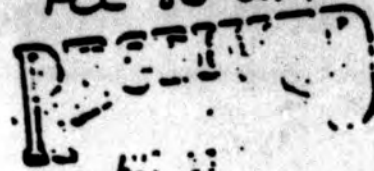
Thank you. I would be happy to answer your questions when that is appropriate.



Commercial Insurance Division
151 Farmington Avenue
Hartford, CT 06155
(203) 273-0123
August 8, 1986

Attachment 1A

FCC-86-2172



ECRMS AND CONTRACTS

Honorable Bill Gunter
INSURANCE COMMISSIONER
Florida Department of Insurance
Tallahassee, FL 32301

ATTN: Mr. Charlie Gray, Chief
Bureau of Policy and Contract Review

Dear Mr. Gray:

RATE REVISION

CONTRACTORS LIABILITY POLICY PROGRAM

✓ **THE AETNA CASUALTY AND SURETY COMPANY**

THE STANDARD FIRE INSURANCE COMPANY

THE AUTOMOBILE INSURANCE COMPANY OF HARTFORD, CONNECTICUT

In accordance with your Insurance Laws, our Companies file a revised liability rate level which results in an overall selected premium increase of 17.2% with an annual premium effect of \$622,250.

Our Companies' decision to revise rates results only after a thorough and comprehensive analysis. We evaluated our experience, market conditions, tort reform, and other relevant factors as they affect the establishment of adequate rate levels. The enclosed exhibits prepared by actuarial unit are submitted in support of our rate filing decision, and demonstrate that the resultant rates are neither excessive, inadequate, nor unfairly discriminatory.

We propose to implement this filing with respect to all policies written on or after January 1, 1987. So as to not delay the filing of our rate level decision, revised rate pages will be forwarded under separate cover when available.

A stamped, self-addressed envelope is enclosed for your convenience in responding.

Sincerely,

Thomas L. Rudd, Superintendent
Insurance Department Affairs - Commercial Lines

BODILY INJURY CLAIM COST IMPACT OF FLORIDA TORT LAW CHANGE

Summary

The following table summarizes the expected impact of the new Florida law on bodily injury claims costs (including Allocated Loss Adjustment Expenses). The impacts shown were developed from data gathered via a special claim study conducted by the Aetna. The claim study and the analysis are detailed in the succeeding sections of this memorandum.

Impact of Tort Law Changes

Impact of Tort Law Changes

<u>Tort Law Change</u>	<u>Line of Business</u>	
	<u>Products</u> <u>Bodily Injury</u>	<u>All Other</u> <u>General Liability</u>
Collateral Source Offset	0	(0.4X)
Joint & Several	0	0
Limitation of Noneconomic Damages to \$450,000	0	0
Punitive Damages	0	0
Future Economic Damages over \$250,000 Paid at Present Value	0	0

All Other General Liability includes the bodily injury liability portion of package policies, SMP Section II, and monoline General Liability policies. The analysis as shown is based solely on Aetna data and, therefore, is applicable only to Aetna's book of business.

Claim Study

The attached special claim analysis form, designed to gather data on the impact of the tort reforms, was completed by experienced Branch Office claim personnel. Claims eligible for analysis were selected according to the following criteria:

1. Commercial Casualty claims (excluding National Accounts business) for policy years 1981 through 1985
 - a. reported prior to January 1, 1986
 - b. open as of May, 1986
 - c. closed during the last six months
2. All claims in category (1) with indemnity payments or reserves over \$25,000 were analyzed (total of 55 claims).

3. Fifty closed claims with indemnity of less than \$25,000 were randomly selected.

The completed forms were reviewed for internal consistency prior to coding and analysis.

Collateral Source Analysis

Exhibits I and II detail the analysis of the revision in the collateral source rules. Exhibit I is for claims over \$25,000 indemnity. Exhibit II is for claims under \$25,000 indemnity.

Exhibit I shows that since the right of subrogation exists for many collateral sources available to the plaintiff, the economic losses incurred are not expected to be substantially reduced due to the law change. Furthermore, current Aetna claim settlement practices recognize, in part, the existence of collateral sources as part of the negotiating process used in arriving at a mutually satisfactory damage value with the plaintiff.

Exhibit II shows that for claims under \$25,000, no additional savings are expected due to the change in Florida law.

Joint and Several Analysis

Exhibit III details the analysis of joint and several additional payments made by Aetna. Total joint and several payments were 4.5% of indemnity payments over \$25,000. A review of each claim generating additional payments due to joint and several liability indicated no reduction in those payment due to the interaction of economic damages sustained by the plaintiff, the percentage of liability assigned to Aetna's insured, and the policy limits purchased.

Analysis of Limitation of Noneconomic Damages to \$450,000

Nine claims had the potential for coming under the new limitation for noneconomic losses. The nine cases were identified on the basis of full liability value—not our insured's share of the liability. Data in the above format allowed for a review of whether total claim value could be reduced and whether such a reduction would impact on Aetna's incurred claim cost.

The review of the actual data submitted on these cases indicated no reduction of cost. This result is due to the impact of degree of disability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff; all seemed to reduce the expected noneconomic component of damages to less than \$450,000.

Analysis of Punitive Damages

Only two cases were found where punitive damages had an impact on the claim settlement value. The total impact was estimated at less than \$15,000 or less than 0.1% of total indemnity payments. Consequently, it appears that there will be no impact on Aetna's claim values due to changes in the allocation of the punitive damages awarded.

Analysis of Installment Payment of Future Economic Damages Over \$250,000

Ten claims had the potential for coming under this section of the law. The review of individual cases indicated no net savings to Aetna for the following reasons:

1. interaction of policy limits, past economic losses, and future economic losses
2. settlement value of the case
3. apparent implicit recognition of the periodic nature of future damages

Overall Summary

The expected net reduction in claim costs is based on an analysis of Aetna claims. As such, the analysis is applicable only to Aetna's book of business.

Due to the level of detail of the historical claim data, informed claim judgement was required in some instances to ascertain some of the detail required for the analysis. The judgement, if any, was exercised by experienced claim adjusters and is implicit in the analysis.

The analysis shown represents the best estimate of future cost reductions if the law as currently structured remains in effect. However, the sunset provision of the law takes effect in four years. Furthermore, the law applies only to cases filed under the law, and the Florida statute of limitations is four years. Consequently, it is possible that any plaintiff who might be severely impacted by the provisions of the law would delay filing until after the law expires. If this situation arises, then the expected reductions will be lower than those indicated in this memorandum.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM

In 1986, Florida passed a number of changes to the tort system. We have reviewed the tort changes and their potential effect on our medical professional liability experience. Our review is based on a study of over 300 Florida closed claims. The total effect of the bill based on this evaluation was very small.

Evaluation:

Of the 313 closed claims that were studied, only four claims would have been effected by the law for a total effect of about 1% savings. (Exhibit A) Furthermore, all of these savings would have been eliminated if the courts had assigned only 10% more of the blame on our insureds than our claim department had estimated. It's highly likely that there would have been no savings on these claims had the bill been in effect. (Exhibit B)

Our study covered all of our Florida physicians, surgeons and hospital claims that closed in 1983 and 1984. Economic loss was determined based on the plaintiff's medical loss, weekly wage, and time lost from work. These losses were reduced for the time value of money.

We added the noneconomic loss cap to the total economic losses. The cap is \$450,000 times the portion of negligence assigned to our insured. We compared this maximum award under the new law to the amount that the St. Paul actually paid on behalf of our insured.

The conclusion of the study is that the noneconomic cap of \$450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above \$250,000 will produce little or no savings to the tort system as it pertains to medical malpractice.

Comments on other provisions of the bill:

a. Collateral source offset

The medical malpractice provisions prior to this act provided for subrogation against collateral providers. The effect of this subrogation would be similar to the effect of the collateral source rule. Therefore, the net effect of eliminating the subrogation and allowing collateral sources is negligible.

b. Itemization of Damages

Damages were itemized in our evaluation of this tort reform and no savings were shown. They are probably already implicitly itemized by either juries or our claim department when settling claims. We expect no savings from this provision.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM
(Continued)

c. Frivolous Suit Protection

This provision can either work for or against us depending on who wins the case. No savings are expected from it.

d. Additur/Remittitur

This provision can also work for or against us. No savings are expected.

e. Punitive Damages

The legislation reduces the monetary incentive for punitive damage cases, but not total award amounts. Since these cases often have a retaliatory incentive, no savings are expected.

f. Timing of Effects

The tort changes made in Florida apply to losses occurring on or after July 1, 1986. On a claims-made policy, they will effect only the portion of our expected losses with accident date after July 1, 1986. This will impact the equivalent of our first year losses.

g. Conclusion

The tort law changes effective July 1, 1986 in Florida will, hopefully, have a positive impact on loss costs for occurrences after that date. However, to forecast the effect is highly speculative. Our evaluation of prior losses showed little or no savings under key provisions of the law and our analysis of other provisions show no expected savings. Our best estimate is no effect from the tort changes.

It can be hoped that the adoption of these tort changes will have an intangible effect on society, and further work to mitigate future loss trends. However, the trends in medical malpractice have been very high. The effect of the reform needs to be very strong to stem such trends.

State Farm Fire and Casualty Company
State Farm General Insurance Company

112 E. WASHINGTON ST.
BLOOMINGTON, ILLINOIS 61701

October 21, 1986

Mr. Ray Rathert
Kansas Insurance Department
420 S. W. 9th Street
Topeka, Kansas 66612

Ray:

Before any discussion of State Farm and tort reform, it must first be clearly understood that most of the problems in the liability field are in lines which State Farm does not write. Because of this, the impact of tort reform on our book of business is going to be considerably different from that of a major liability writer.

We have been requested by several insurance departments to come up with some estimate of the effect of newly passed tort reform ~~legislation on our rates in~~ their states. We know of no way this can be done actuarially. Consequently, we resorted to judgement.

The few enacted tort reform statutes usually include items such as:

- 1) Collateral source of indemnity
- 2) A non-economic cap
- 3) Joint and several restriction
- 4) Punitive damage limitation
- 5) Alternate methods of payment.

A sampling of commercial liability claims provided the following:

- 1) Collateral source of indemnity. The sample indicated that approximately 7% of our total indemnity losses were potentially subject to a collateral source. Only about a quarter of these reflected a known collateral source. In our judgement, 50% would be a very liberal estimate of the success in reducing damages due to the existence of a collateral source. The net savings from the collateral source change is thus about 1% (7% X 25% X 50%).
- 2) Non-economic cap. Non-economic caps are established at such a level that our sample indicated only very few claims would exceed the cap. It is our judgement that the loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses.

- 3) Joint and several restriction. In our sample of liability claims, no claim was found that would have ~~been affected by the joint and several restriction.~~
- 4) Punitive damage limitation. Again, in our sample, no punitive damage awards were found.
- 5) Alternative methods of payment. On our book of business, the savings due to alternative payment methods on future economic losses would be negligible in relation to our total indemnity losses.

~~Although we believe the effect of tort reform on our book of business would be small,~~ we do believe that effective tort reform legislation can have a positive impact on not only pricing but also availability. It is important to keep in mind that tort reform, or absence thereof, is only one of many factors which influence pricing and availability. Any of these other factors can produce an opposite effect which could equal or outweigh any positive effect of tort reform.

Attached are liability rate comparisons for Kansas and surrounding states. As you know, we use ISO rates for monoline policies. Even in our package policies, the original liability loadings were also derived from ISO rates.

Again, as you know, we do review our rate levels at least annually. It will ~~probably be several years before any effect from tort reform legislation can be expected to influence our experience.~~ Anyway, hope these brief comments will be of some use to you in your discussions of this subject.

Best regards,



Robert J. Nagel
Assistant Vice President
State Filings Division

RJN:kc/1021



**Effect on Insurance Rates of Florida Tort Reforms -
for all companies filing as of 11/01/86**

<u>% Reduction</u>	<u>Number of Filings</u>				
	<u>Commercial General- Liability</u>	<u>Commercial Package</u>	<u>Auto</u>	<u>Other</u>	<u>Total</u>
0	72	28	31	44	175
0-2.5%	12	25	5	3	45
2.5-5%	18	14	6	0	38
5-7.5%	7	1	7	1	16
7.5-10%	2	1	0	0	3
Over 10%	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Total number of filings	111	69	49	48	277
Average Reduction	-1.3%	-1.5%	-1.5%	-0.2%	-1.2%

Average calculated by assuming all filings are of equal premium weight. Companies that filed rates and did not calculate the effect of the new tort reforms are not included.

Source: Florida Department of Insurance

121 N. Payne Street
Alexandria, Virginia 22314
(703) 549-8050



GREAT AMERICAN WEST, INC.

200 S. MANCHESTER AVENUE
ORANGE, CA 92668
714/634-4600

April 23, 1986

Mr. Norman Figon
Rate Analyst
Washington Insurance Department
Insurance Building
Olympia, WA 98504

Re: American National Fire Insurance Company
Select Driver I Program
Select Driver I Program
Private Passenger Automobile
Rate and Rule Revision

Dear Mr. Figon:

In your letter of March 25, 1986, you indicated that we need to place a provision in our ratemaking to reflect the impact of the "tort reform" law. As an attempt to quantify, we reviewed twenty-four claim files, which represented all of our Private Passenger Automobile claims over \$50,000 in the state of Washington since 1983. Of these twenty-four claims, we believe that the new law could have an impact on three claims. One claim involved a driver that was intoxicated. We estimate that we would not have paid \$20,000 of the claim. On the other hand, there were two claims in which American National Fire would see an increase in its loss liability. These are contributory negligence cases in which our percent of the entire loss liability would increase. The impact of the law on these two is at least \$100,000 on each of them.

From the above study, it does not appear that the "tort reform" law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the "tort reform" law.

We request, therefore, that you reconsider the original filing of January 19, 1986, with an amended effective date rule of:

"For all policies written on or after June 2, 1986".

April 23, 1986
Mr. Norman Figon
Page 2

In our telephone conversation you mentioned a concern that we are selecting an increase less than our indications. Our plan of action is to take this increase, which we estimate to be slightly more than 14%, and to review the rates in the near future, such that we can effect a rate change six months after the effective date of this revision. We believe that this method will prove to be less disruptive on our book of business than other courses that we might have chosen.

We hope the above includes all the information that you need to expedite an approval of the filing.

Sincerely,


Kevin J. Kelley
Director of Actuarial

KK/nk

CHIEF EXECUTIVE circular

Attachment 5

	DIB
	EMC
	HAI
	WES
	KAC

RECEIVED

OCT 14 1986

ISO DALLAS

October 3, 1986

ISO POLICY DECISION ON TORT REFORM ANNOUNCED

Chief Executive CE-86-31

BACKGROUND

Various tort reform measures have been enacted or are still under active consideration in many states. It is clear that meaningful tort reform will have a favorable, prospective impact on loss severity and/or frequency, variable by state and line of insurance which, ultimately, will be reflected in state loss experience.

However, in some jurisdictions, an immediate rate reflection in response to tort reform is being demanded. Statutes in Florida, New York and Hawaii mandate that insurers reflect tort reform legislation in their filings. The New York Insurance Department has already advised companies of its estimates of the cost reductive effects of tort reform. Florida has mandated a 1987 rollback to adjusted 1984 rates, unless companies file 1987 rates reflecting the impact of tort reform by October 15, 1986. Hawaii has mandated a 10% decrease in rates on October 1st to reflect tort reform, with further reductions required in future years. The Washington Insurance Department is requiring that future rate filings reflect enacted tort reform even without a specific statutory requirement.



Insurance Services Office, Inc., 160 Water Street, New York, New York 10038 (212) 487-5000

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ISO POSITION

ISO is unable to quantify, and to reflect in its filings with a reasonable degree of certainty, any immediate cost effects of tort reform. ISO believes that the reflection of any beneficial effect of tort reform on insurance pricing, where mandated, is a matter of individual insurer judgment and not a precise actuarial exercise. Such judgment is consequently more properly applied by individual insurers, rather than by ISO in its role of acting on behalf of those affiliated insurers which elect to use ISO's services.

Therefore, the ISO Board of Directors has established -- as ISO policy -- that, inasmuch as ISO cannot immediately reflect any cost effects of tort reform in its filings, any such effects are best determined by the judgment of each insurer, taking into account the distribution by coverage, class, and limits on its own book of business.

ISO ACTION

Consistent with this policy, ISO advisory rates will not reflect tort reform and each company must make its own assessment as to the immediate effect, if any, of tort reform on its book of business.

In New York, in order to assist companies in complying with the refiling requirements of the new law, ISO released Commercial Lines Circular CL-86-29 which contained revised manual rules utilizing the cost reductive effects promulgated by the Superintendent of Insurance, without commenting on their appropriateness.

In Florida, ISO has developed a filing procedure -- which has been approved by the Insurance Department -- whereby individual companies must supplement the ISO filing with their own individual estimates of the impact of tort reform. At the direction of the Insurance Department, ISO will collect these individual estimates and file them on behalf of each insurer. Refer to ISO Commercial Lines Circular CL-86-33 for specific details.

ADDITIONAL INFORMATION

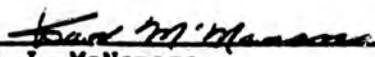
ISO plans to shortly provide insurers with information which could be considered by each company in reflecting any effect of tort reform, including an analysis of the tort reform measures enacted in individual states.

CIRCULAR

Within the next several days, ISO will release such information to insurers via Commercial Lines and Technical Services Circulars. In anticipating receipt of this material, each insurer should note ISO's strong belief that any beneficial effects of tort reform cannot be quantified with any degree of accuracy. Accordingly, providing any quantitative information does not imply that any actuarial precision can be applied to what is -- in effect -- an imprecise subject. However, the information may aid individual insurers in supplementing their judgment which, ultimately, will be the major factor in determining any beneficial pricing effect of tort reform.

CAUTION

In Circular CL-86-33 we detailed the Florida filing procedures which must be completed by October 15th. Since -- to avoid the rollback -- Florida rate filings require individual insurer estimates of the cost effects of tort reform and, since the judgment of each insurer will be the major component in arriving at these estimates, we urge individual insurers to promptly begin developing their own estimates, without waiting for the ISO material on tort reform which, as heretofore mentioned, will not produce precise results.


Daniel J. McNamara
President

cc: ISO Board of Directors
Actuarial Committee
Commercial Lines Committee
Personal Lines Committee



INSURANCE SERVICES OFFICE

160 WATER STREET NEW YORK, N. Y. 10038

TELEPHONE: (212) 467-5000

COMMERCIAL CASUALTY ACTUARIAL DIVISION
RICHARD S. BIONDI, ASSOCIATE ACTUARY & MANAGER

October 15, 1975

RECEIVED
AUTO & COMPENSATION
INSURANCE BUREAU

OCT 15 1975

Mr. Stanley A. Dorf, Chief Actuary
New York Insurance Department
2 World Trade Center
New York, New York 10038

INSURANCE DEPT.
STATE OF N. Y.

Re: Comparative/Contributory Negligence -
Automobile Liability Rate Change Proposal

Dear Mr. Dorf:

Because of the change in the New York law from contributory negligence to comparative negligence, I.S.O. proposes to increase Automobile Liability (including Uninsured Motorists) rates by 5%. This proposed increase is based on a study of closed Automobile Liability claims in California, comparing the actual settlement under the comparative negligence law with the estimate of what it would have been under the earlier contributory negligence law. Enclosed is Exhibit 1 displaying the indicated rate changes by line and coverage based on the survey, and also the proposed changes of 5% for the liability coverages and "no change" for Personal Injury Protection. Exhibit 2 details the results of the claim study survey, showing number of claims, losses under both negligence laws, and comparative/contributory ratios, by line and coverage.

We have also enclosed a copy of the "Call" letter used for this survey; in it can be found a sample copy of the questionnaire form and the general instructions for completing the form. The companies participating in the study write approximately 75% of the Automobile Liability premiums written by Insurance Services Office affiliated companies. All claims reported to us were settled very shortly after the changeover in negligence laws in California; thus, claims personnel completing these forms were in a good position to compare comparative vs. contributory settlements for their claims.

Very truly yours,

George Burger
Actuarial Assistant

GB:cm
Enc.

New York

Automobile Liability Insurance

I.S.O. Proposed Rate Increases to Reflect the Change from Contributory to Comparative Negligence*

<u>Coverage</u>	<u>Indicated Rate Change</u>	<u>Proposed Rate Change</u>
Private Passenger		
Residual Bodily Injury	+ 4.1%	+ 5.0%
Personal Injury Protection	-	0.0
Property Damage	+ 4.6	+ 5.0
Uninsured Motorists	+13.0	+ 5.0
Total	+ 4.8	+ 4.4
Commercial		
Residual Bodily Injury	+ 6.8%	+ 5.0%
Personal Injury Protection	-	0.0
Property Damage	+ 6.9	+ 5.0
Uninsured Motorists	+ 0.1	+ 5.0
Total	+ 6.5	+ 4.7
Grand Total	+ 5.4%	+ 4.4%

*Note that all percent changes are weighted on New York's premium distribution.

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FROM FIGURES



BEST'S EXECUTIVE DATA SERVICE

1987

ALASKA

EXPERIENCE BY STATE
- OTHER LIABILITY

A2-02-17

COMPANY	MKT. SHR.	DIRECT PREMIUMS		DIVIDENDS TO POLICYHOLDERS	DIRECT LOSSES		LOSS RATIOS			Group Rank: Overall Rank	
		WRITTEN w	EARNED e		PAID d	INCURRED i	d/w	i/e	Adj. Prem. Ratio	Ratio	Ratio
AETNA LIFE & CAS GRP	1.8	1 168	1 366		87	864	7.5	63.3	63.3	8	13
AMER FINANCIAL GROUP	1.2	793	896		211	312	26.6	34.8	34.8	10	13
AMER GENERAL GROUP		81	81			3		32.0	32.0	23	71
AMER INTERN GROUP	23.2	15 139	13 187		5 750	8 294	38.0	62.9	62.9	1	29
ATLANTIC MUTUAL COS						-1		-99.9	-99.9	28	41
CHUBB GRP OF INS COS	1.9	1 255	1 168			212		18.1	18.1	7	14
CIGNA GROUP	6.9	4 509	4 282		-1 325	-3 209	-29.4	-74.9	-74.9	2	3
CNA INS COMPANIES	4.4	2 878	3 111	7	481	1 571	16.7	50.5	50.5	4	6
COMM UNION INS COS		21	21			-14		-99.9	-99.9	26	86
CONTINENTAL INS COS	1.5	967	960		1 515	-1 265	156.7	-99.9	-99.9	9	18
CRUM & FORSTER COS	6.2	4 047	4 175		2 427	2 704	60.0	64.8	64.8	3	10
FIREMAN'S FUND COS	3.8	2 457	2 491	1	457	1 805	18.6	72.5	72.5	5	11
GENERAL ACC GROUP		1	11		1 865	1 155	999.9	999.9	999.9	27	89
HANOVER INS COS		4	4			7.6		7.6	7.6	25	82
HARTFORD INS GROUP	.9	565	618		2 881	3 880	510.3	628.2	628.2	12	16
HOME INS GROUP	1.1	739	566		4 359	1 789	589.5	316.2	316.2	11	15
KEMPER GROUP	.2	156	148			21		14.0	14.0	17	43
LINCOLN NAT GROUP		1									92
NORTHWESTERN NAT GRP					-95	-100	999.9	999.9	999.9		
ORION GROUP	2.3	1 479	1 418			-54		-3.8	-3.8	6	11
RELIANCE INS COS	.1	72	73		31	10	43.5	14.1	14.1	21	53
ROYAL INS GROUP	.5	348	297		1	-152	.3	-51.2	-51.2	14	27
SAFECO INS COMPANIES	.3	170	134		27	75	15.9	56.0	56.0	15	7
ST PAUL GROUP	.1	74	106			34		31.8	31.8	19	4
TRANSAMERICA INS GRP	.2	133	105		12	78	9.3	74.3	74.3	18	12
TRAVELERS INS GROUP	.3	164	159		1 215	-523	738.8	-99.9	-99.9	16	41
UNIGARD INS GROUP		5	24			24					80
UNITED STATES F&G GR	.6	418	643		122	782	29.1	121.6	121.6	13	14
UTICA NATIONAL GROUP		11	61			2		32.7	32.7	22	68
ZURICH INS GROUP-U S	.1	72	149			124		82.9	82.9	20	13
NATL.AGENCY COS 30*	57.6	37 635	36 106	8	20 021	18 394	53.2	51.0	51.0		
ALASKA NATIONAL INS	11.8	7 706	7 917		1 736	2 672	22.5	33.8	33.8	1	6
AMER MODERN HOME GRP	.1	63	63		4	9	7.0	13.9	13.9	27	2
AMERICAS INS CO	.3	215	266			604		227.0	227.0	14	18
W R BERKLEY CP GROUP	1.9	1 268	1 897		751	328	59.2	17.3	17.3	5	3
BERKSHIRE HATHAWAY	.5	345	543		7	75	2.0	13.8	13.8	11	1
CLARENDON INS GROUP	.1	42	42			52		123.4	123.4	28	56
ELITE INS CO USB	.1	40	34			-1		-2.2	-2.2	29	58
EMPLOYERS CAS GRP TX		14	24							34	66
EMPLOYERS RE GROUP	.5	319	323		121	115	38.0	35.5	35.5	12	8
EVANSTON GROUP	1.5	1 009	1 231		282	481	28.0	39.1	39.1	7	9
FOREMOST CORP GROUP		32	45		32	14	98.5	30.3	30.3	30	60
FREMONT INS GROUP		17	31		321	1 444	999.9	999.9	999.9	33	65
GENERAL AGENTS GROUP	.3	177	187		4	-113	2.4	-60.5	-60.5	19	37
GUARANTY NAT CORP GR	.3	173	96			33		34.8	34.8	20	7
HIGHLANDS INS GROUP	1.7	1 088	1 105		-157	-130	-14.4	-11.7	-11.7	6	16
ILL. EXCH. COMPOSITE	.3	193	227			-190		-83.6	-83.6	18	36
IMPERIAL CAS & INDEM		23	4		-5	-3	-20.6	-77.1	-77.1	32	63
INTECON CORP GROUP		14	1				1.0	32.1	32.1	35	67
NORTH ATLANTIC C & S	.1	69	43			10		24.0	24.0	26	54
NORTHLAND GROUP	2.3	1 522	1 200		7	737	.4	61.4	61.4	3	14
OLD REPUBLIC GROUP	1.2	775	1 329		567	1 401	73.1	105.4	105.4	8	16
PACIFIC MARINE GROUP	.9	582	979		294	-364	50.5	-37.2	-37.2	9	23
PENN-AMERICA INS CO	.1	82	99		25	-4	30.3	-3.9	-3.9	25	50
PROGRESSIVE GROUP	.2	103	76			44		58.1	58.1	22	12
PROVIDENCE MASH GRP	2.1	1 399	1 380		2 346	254	167.7	18.4	18.4	4	4
RLI GROUP	.1	96	59			66		111.6	111.6	23	17
ROCKWOOD GROUP	.6	377	443		25	203	6.5	45.9	45.9	10	11
SAFETY MUTUAL CAS CP	2.6	1 687	1 679		91	1 031	5.4	61.4	61.4	2	13
TOKIO MAR & FIRE GRP	.3	205	182			117	2.1	64.0	64.0	16	15
TOPA INS CO		11	40		14	65	122.1	160.9	160.9	36	69
UMIALIK INS CO	.3	203	188		681	54	335.8	28.7	28.7	17	5
UNITED CAPITOL INS	.4	267	200			90		44.7	44.7	13	10
UNITED NATIONAL GRP	.2	110	85		500	761	454.3	895.9	895.9	21	20
WESTCO INS GROUP	.3	212	304		3 135	2 610	999.9	858.3	858.3	15	19
WILLIS FABER GROUP		25	39			4		11.4	11.4	31	62
YASUDA FIRE & MARINE	.1	92	21			9		41.6	41.6	24	49
OTHER COS 33*	-1.1	-76	-331		6 473	-1 745	-99.9	526.9	526.9		
STATE AGENCY CO 69*	31.3	20 479	22 052		17 258	10 733	84.3	48.7	48.7		
ALLSTATE INS GROUP	.5	298	275		50	168	16.9	61.1	61.1	4	6
COLONIAL PENN GRP		11	28		11	487	102.2	999.9	999.9	12	70
CUNA MUT INS GROUP		32	32			3		8.7	8.7	10	61
GEICO CORP GROUP		2	3					-6.1	-6.1	20	85
GENERAL RE GROUP	2.6	1 671	1 616			1 006		62.2	62.2	2	7
JOHN DEERE GROUP	.3	174	144		13	83	7.3	57.6	57.6	5	5
LIBERTY MUTUAL GROUP	.3	164	170		61	27	37.2	15.9	15.9	6	1
MOTORS INS GROUP		21	23			29		125.7	125.7	11	64
NATIONWIDE GROUP	5.9	3 826	3 774		2 115	1 898	55.3	50.3	50.3	1	3
NAVIGATORS INS CO	.1	41	19			13		65.0	65.0	8	57
PRUDENTIAL OF AM GRP	.1	34	4		2	-93	7.1	-99.9	-99.9	9	59
SENTRY INS GROUP		81	71					4.3	4.3	13	72
STATE FARM GROUP	1.3	864	759		468	435	54.2	57.3	57.3	3	4
USAA GROUP	.2	115	123	8	4	56	3.3	45.8	45.8	7	2
OTHER COS 14*	-14	-483			586	-335	-99.9	-69.2	-69.2		
DIRECT WRITERS 28*	11.1	7 247	7 460	9	3 310	3 776	45.7	50.6	50.7		
TOTAL * 127*	100.0	65 361	65 618	17	40 589	32 904	42.1	50.1	50.2		

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BEST'S EXECUTIVE DATA SERVICE

1987
ALASKA

EXPERIENCE BY STATE
- MEDICAL MALPRACTICE

A2-02-50

COMPANY	MKT. SHR.	DIRECT PREMIUMS		DIVIDENDS TO POLICYHOLDERS	DIRECT LOSSES		LOSS RATIOS			Group Rank: Overall Rank			
		WRITTEN w	EARNED e		PAID p	INCURRED i	d/w	i/e	Adj.	Prem.	Ratio	Prem.	Ratio
AETNA LIFE & CAS GRP	.8	130	130		500	-279	383.4	-99.9	-99.9	4	8		
AMER INTERN GROUP	2.9	447	298			158		53.0	53.0	2	2	5	5
CHUBB GRP OF INS COS					116	25							
CIGNA GROUP	.1	10	8		33	-379	345.2	-99.9	-99.9	8	15		
CNA INS COMPANIES	10.7	1 670	1 678		590	1 129	35.3	66.5	66.5	1	3	3	7
CONTINENTAL INS COS	.6	66	45			16		36.1	36.1	5	10		
CRUM & FORSTER COS		-2				-183		-99.9	-99.9				
FIREMAN'S FUND COS	.4	64	59			-21		-36.3	-36.3	6	11		
HARTFORD INS GROUP		2	4					.1	.1	9	19		
HOME INS GROUP													
ST PAUL GROUP	1.0	162	96			3		3.6	3.6	3	1	7	1
TRAVELERS INS GROUP	.4	59	59		-1	51	-1.7	86.3	86.3	7	4	12	9
NATL.AGENCY COS 12*	16.7	2 608	2 398		1 238	521	47.5	21.7	21.7				
M R BERKLEY CP GROUP	.2	34	31			25		82.3	82.3	2	13		
DOCTORS CO INTER EX		2	2							7	20		
EVANSTON GROUP	1.1	174	668			521		78.0	78.0	1	1	6	8
ILL. EXCH. COMPOSITE		4	1							6	18		
JEFFERSON INS GROUP		2	2			1		48.1	48.1	8	21		
MMI COMPANIES GROUP		5	2			1		68.0	68.0	5	17		
RLI GROUP	.1	9	8			8		96.1	96.1	4	16		
WESTCO INS GROUP	.1	13	18			-13		-72.9	-72.9	3	14		
OTHER COS 2*													
STATE AGENCY CO 10*	1.6	242	731			442		74.1	74.1				
ALLSTATE INS GROUP						773							
HEALTH CARE INDEMN	5.9	920	964		152	545	16.5	56.6	56.6	3	4	4	6
MEDICAL INDEMN ALASK	44.6	6 937	6 937		5 928	3 524	85.5	50.8	50.8	1	3	1	4
MEDICAL INS EXCH CAL	30.7	4 777	3 724		1 281	1 265	26.8	34.0	34.0	2	1	2	2
NAT CHIROPRACTIC MUT	.5	85	77			31		41.0	41.0	4	2	9	3
OTHER COS 1*						-1							
DIRECT WRITERS 6*	81.7	12 719	11 701		7 362	6 138	57.9	52.5	52.5				
TOTAL	28*	100.0	15 569	14 831	8 599	7 201	55.2	48.6	48.6				

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